

ABSTRACT

Title of Thesis: PREDICTORS OF SUPERVISOR ABILITY
TO DETECT SUPERVISEE
COUNTERTRANSFERENCE TOWARD A
BISEXUAL CLIENT

Melissa Stephanie Roffman, Master of Arts, 2005

Thesis Directed By: Professor Charles Gelso
Department of Psychology

This study was a laboratory analogue examining the relationships among supervisor biphobia, supervisor countertransference (CT) reactions (to a supervisee's bisexual client), and supervisor accuracy of detection of a supervisee's CT to the bisexual client. Participants were 47 graduate and postgraduate level supervisors who listened to a 20 minute analogue counseling session in which a fictitious heterosexual male supervisee exhibits CT behaviors toward a bisexual male client, as judged by 5 experts in CT on the Inventory of Countertransference Behavior (Friedman & Gelso, 2000). Supervisors' ratings of the amount of CT behavior in the session were compared to the average of experts' ratings to determine supervisors' CT detection accuracy; supervisors' biphobia and CT were also assessed. Results suggested that higher supervisor biphobia predicted greater accuracy of detection of negative CT toward the bisexual client, although this result must be interpreted in the context of the low overall biphobia in the sample. Implications for research and practice are discussed.

PREDICTORS OF SUPERVISOR ABILITY TO DETECT SUPERVISEE
COUNTERTRANSFERENCE TOWARD A BISEXUAL CLIENT

by

Melissa Stephanie Roffman

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Advisory Committee:

Professor Charles Gelso, Chair
Professor Ruth Fassinger
Professor Mary Ann Hoffman

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Chapter 1

Introduction

Despite improvements in the past 30 years in society's acceptance of sexual minorities, as well as a recent groundbreaking Supreme Court decision declaring same-sex relations legal, sexual minorities continue to suffer from the effects of societal stigma, ranging from prejudice to denial of legal and social rights, and even to violence (Ritter & Terndrup, 2002; Herek, 1995; Fassinger, 1991). In addition to these external stressors, sexual minorities may also be coping with internalized homophobia, the stress of being "closeted" and feelings of invisibility, a sense of being different and isolated, and a lack of positive role models (Dworkin, 2000; Hancock, 1995). Thus, it is not surprising that sexual minority individuals utilize counseling services at a high rate (Liddle, 1997; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Cochran, Sullivan, & Mays, 2003). These stressors may also explain why sexual minorities are at greater risk for some mental disorders than heterosexuals (Cochran et al., 2003; Meyer, 2003).

At the same time, sexual minorities may have difficulty finding therapists who are affirmative and knowledgeable about LGB lifestyle and health issues (Liddle, 1996; Garnets et al., 1991). Despite the American Psychological Association's declassification of sexual orientation as a mental disorder in 1975, many therapists still operate under the belief that sexual minorities are disordered (Fassinger, 1991; Goldfried, 2001). These therapists may conduct therapy in ways that are unhelpful to their LGB clients (Garnets et al., 1991; Liddle, 1996; Morrow, 2000). Reasons why these therapists persist in viewing sexual minorities as disordered may include religious biases, societal norms, gender roles,

fears around sexuality, and ignorance stemming from insufficient knowledge or contact with sexual minority individuals (Morrow, 2000; Long, 1996; Emert & Milburn, 1996; Herek & Glunt, 1993). In response to the problems faced by LGB clients who have received unhelpful or even harmful treatment from such therapists, the American Psychological Association (APA) established ethical guidelines for psychotherapy with LGB clients in 2000; this has been accompanied by repeated calls for increased attention to these issues in graduate training (e.g., APA, 2000; Buhrke & Douce, 1991; Phillips & Fischer, 1998). While an increasing number of graduate counseling programs include training (both didactic and experiential/practical) specific to counseling sexual minority clients, research indicates that training has often been insufficient or inadequate to prepare trainees to work competently with these clients (Phillips & Fischer, 1998; Buhrke & Douce, 1991; Phillips, 2000; Murphy, Rawlings, & Howe, 2002; Buhrke, 1989).

When it occurs, training specific to sexual minority clients may be particularly focused on counseling lesbians and gays, as has generally been the focus of counseling literature (Phillips & Fischer, 1998; Fox, 1996; Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Buhrke, Ben-Ezra, Hurley, & Ruprecht, 1992). There is comparatively little research on counseling bisexuals, though some research suggests that even therapists competent in working with lesbians and gays may have difficulty comprehending and addressing the complexity of bisexual issues, and that training is particularly lacking in this area (Matteson, 1996; Murphy et al., 2002; Phillips & Fischer, 1998; Phillips, 2000).

It seems important for such training to occur, however, given the variety of stressors that may lead bisexuals to seek counseling services (Guidry, 1999; Firestein,

1996; Fox, 1995; Robin & Hamner, 2000). In addition to encountering the stressors common to all sexual minorities, bisexuals may also be stigmatized for violating the dichotomous view of sexuality, the notion of gender as a determinant of romantic object choice, and the notion of sexual identity as fixed (Firestein, 1996; Guidry, 1999; Ochs, 1996; Queen, 1996). They may often have their sexual identity invalidated by being presumed to “really” be gay or heterosexual (Ochs, 1996; Robin & Hamner, 2000). Negative stereotypes of bisexuals abound, deeming bisexuals promiscuous, unstable, immature, pathological, and untrustworthy romantic partners (Firestein, 1996; Guidry, 1999; Rust, 1996). For bisexual adolescents and college students, bisexuality may be viewed as being part of a larger problem of identity diffusion, rather than a legitimate and stable sexual orientation (Robin & Hamner, 2000; Mohr, Israel, & Sedlacek, 2001). Bisexuals may also have a difficult time finding a community to turn to for support and identification, lacking a bisexual community yet not being accepted fully by either the gay or straight communities (Firestein, 1996; Guidry, 1999; Ochs, 1996; Robin & Hamner, 2000).

Training may be necessary to educate beginning therapists about these bisexual issues and concerns, as beginning therapists may have little firsthand knowledge from personal experience (Phillips & Fischer, 1998; Phillips, 2000; Morrow, 2000). Moss (1995) found that bisexual clients reported more heterosexist bias in their therapists than did gay or lesbian clients. Trainees may not be aware of their heterosexist biases or biphobic attitudes, which can nevertheless have a negative impact on their work with bisexual clients (Garnets et al., 1991; McHenry & Johnson, 1993; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993). Experienced therapists who supervise

trainees may likewise have heterosexist biases (Garnets et al., 1991; Graham, Rawlings, Halpern, & Hermes, 1984; Long, 1996; Russell & Greenhouse, 1997; Pilkington & Cantor, 1996). In order to supervise trainees working with bisexual clients effectively, supervisors may need to engage in ongoing training themselves, such as continuing education or peer consultation (e.g., Phillips & Fischer, 1998; APA, 2000). Also, in the case of both beginning trainees and their more experienced supervisors, self-reflection on one's biases, blind spots, and unresolved issues around bisexuality remain important (Long, 1996; Russell & Greenhouse, 1997; Phillips, 2000). Without such self-understanding, these biases and conflicts can manifest themselves as countertransference reactions toward bisexual clients, presumably in both supervisee and supervisor (Gelso & Hayes, 2001; Gelso & Mohr, 2001; Long, 1996).

Countertransference

Seeing clients can be an exciting and bewildering experience for beginning therapists, bringing up a variety of strong and sometimes unexpected reactions to the process and to the clients themselves (Bernard & Goodyear, 1998; Williams, Judge, Hill, & Hoffman, 1997). Among the reactions experienced by beginning therapists and seasoned therapists alike is countertransference, a complex and variously defined construct that can generally be thought of as the therapist's reaction to clients and client issues that touch upon unresolved issues in the therapist (Gelso & Hayes, 2002).

Countertransference reactions may be manifested as either avoidance of or overinvolvement with aspects of client material that are conflictual for the therapist (Bandura, Lipsher, & Miller, 1960; Gelso et al., 1995). Countertransference (CT) may also involve a variety of non-therapeutic or inappropriate behaviors (Friedman & Gelso,

2000). In two audio-visual analogue studies investigating CT toward lesbian and gay male clients, it was found that not just client factors (i.e., sexual orientation) but rather the interaction of client and therapist factors (i.e., client sexual orientation and therapist homophobia) predicted therapist CT reactions to lesbian and gay male clients (Gelso et al., 1995; Hayes & Gelso, 1993). These studies defined CT reactions at the behavioral (verbal avoidance), cognitive (distorted recall of client material), and affective (increased state anxiety) levels.

No studies to date have looked at CT toward bisexual clients, although one study found that biphobia, above and beyond homophobia, predicted *anticipated* negative reactions to a fictitious bisexual client based on an intake (Mohr et al., 2001).

Countertransference toward bisexual clients may be an important topic of investigation, however, given societal stigma toward bisexuality. Morrow (2000) suggests that one possible manifestation of CT toward bisexual clients may involve the therapist rewarding a bisexual client for behaviors that mirror the therapist's own sexual attractions (i.e., opposite-sex if therapist is heterosexual or same-sex if therapist is homosexual), though this idea has not been tested empirically. The present study investigated CT toward bisexual clients using methodology derived from the Gelso et al. (1995) and Hayes and Gelso (1993) studies.

Countertransference has been linked to poor treatment outcomes and working alliance between therapist and client (Hayes, Riker, & Ingram, 1997; Gelso, Latts, Gomez, & Fassinger, 2002; Ligiero & Gelso, 2002), while CT management ability has been linked to better treatment outcomes (Gelso et al., 2002). Given the generally unconscious nature of CT reactions, and given the potential of CT reactions to hinder

therapy or harm the client if acted out, it is of vital importance for all therapists to examine, process, and manage their CT reactions if they are to be maximally helpful to their clients (Gelso & Hayes, 2001).

Countertransference Management through Supervision

Supervision has several major purposes, including building trainee skills (therapeutic techniques as well as case conceptualization, treatment planning, etc); promoting trainee development (e.g., developing professional identity, theoretical orientation, counseling self-efficacy, and multicultural competence); and helping trainees effectively manage their cases (Bernard & Goodyear, 1998; Ladany, Inman, Constantine, & Hofheinz, 1997; Constantine, 1997). For beginning therapists, processing and management of CT reactions takes place primarily in supervision (Williams et al., 1997).

In order for CT management to take place in supervision, presumably the CT must be detected in the first place, either by the supervisee or supervisor. Supervisees may be unable to detect their own CT reactions due to the unconscious nature of CT and, in some cases, their inexperience and lack of familiarity with the experience of a CT reaction (Freud, 1910/1959; Gelso & Hayes, 2002; Williams et al., 1997).

Even when supervisees are able to detect their CT reaction, there are a few reasons why they may hesitate to disclose their reactions to their supervisors. First, the supervisory relationship is inherently power-imbalanced and evaluative in nature; consequently, supervisees may feel concerned about how they are being evaluated and not disclose reactions they feel reflect poorly on their therapy skills and competency (Bernard & Goodyear, 1998; Ladany, Hill, Corbett, & Nutt, 1996; Ward, Friedlander, Schoen, & Klein, 1985). This concern over disclosing CT reactions may be particularly

salient in trainees' work with sexual minority clients. Trainees may be aware that, ethically- or politically-speaking, they *should* exhibit LGB-affirmative attitudes, yet they may have difficulty actually doing so because of personal and culturally reinforced heterosexism, homophobia, and biphobia (APA, 2000; Rudolph, 1988). Trainees might also feel uncomfortable disclosing a CT reaction to a supervisor because it can be revealing of personal conflicts and issues, in this case possibly around the taboo issue of sexuality (Ladany, O'Brien, Hill, Melincoff, Knox, & Petersen, 1997; Ladany et al., 1996). In a study of predoctoral interns' management of sexual attraction to clients, only half disclosed their attraction to their supervisors. One major reason cited for nondisclosure was a poor supervisory relationship (Ladany et al., 1997). Disclosure of sensitive or personal material appears to be difficult for supervisees in supervisory relationships with poor working alliances that do not provide the sense of safety needed to explore supervisees' deeper concerns (Bordin, 1983; Ladany et al., 1996; Ladany et al., 1997). In sum, supervisees may not be able to detect or willing to disclose their CT reactions in supervision. Thus, it may well be left to the supervisor to detect supervisee CT so that it may be managed in supervision.

Since CT detection seems like an important task for supervisors, it is surprising that no research has directly addressed supervisor ability to detect supervisee CT reactions. Supervision has only been implicated in the CT research indirectly in that supervisors have been utilized as raters of therapists' CT behavior and CT management ability (Friedman & Gelso, 2000; VanWagoner, Gelso, Hayes, & Diemer, 1991; Williams et al., 1997). Thus, little is known about what qualities in supervisors contribute to or detract from their ability to detect supervisee CT. Such qualities seem important to

investigate, however, given that supervisees often cite supervisor qualities (e.g., supervisor incompetence) as the reason for nondisclosure of sensitive issues in supervision (Ladany et al., 1996). The present study addressed the issue of supervisor factors related to supervisor ability to detect countertransference.

Supervisor Ability to Detect Countertransference

Research indicates that supervisors can also experience CT reactions, both toward their supervisees and toward their supervisees' clients (Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000). Similar to therapist countertransference, supervisor CT is indicative of unresolved conflicts and issues within the supervisor. These areas of conflict may represent "blind spots" in the supervisor; like therapists, supervisors may not be conscious of the conflict or their reaction (Teitelbaum, 1990; Ladany et al., 2000; Lower, 1972). When supervisors have blind spots or unresolved conflicts in areas similar to those of their supervisee, they may collude with the supervisee to resist approaching the issue (Strean, 1991; Russell & Greenhouse, 1997). Avoidance of conflictual topics in supervision can model avoidance behavior for the supervisee, setting the stage for a parallel process in which the supervisee resists approaching certain topics with his/her clients (Strean, 1991; Friedlander, Siegel, & Brenock, 1989; Doehrman, 1976).

Supervisor CT may be one factor that impacts a supervisor's ability to detect supervisee countertransference. When a supervisor has a CT reaction similar to a supervisee's CT reaction, due to similar unresolved conflicts and issues, it may be difficult for the supervisor to detect the supervisee's CT reaction. Supervisors and supervisees may have similar unresolved conflicts and issues when it comes to bisexuality, due to negative stereotypes and societal stigma toward bisexuality (Ochs,

1996; Guidry, 1999; Morrow, 2000). Thus, a supervisor may have difficulty detecting a supervisee's CT reaction to a bisexual client when the supervisor is also having a CT reaction to the client.

Another supervisor factor that may predict supervisor ability to detect a supervisee's CT reactions is supervisor attitudes toward the supervisee's client, in this case a bisexual client. Supervisor attitudes are related to, but not equivalent to, supervisor CT reactions. We know that therapist attitudes predict therapist CT reactions; for example *therapist* homophobia was found to predict CT reactions toward lesbian and gay male clients (Gelso et al., 1995; Hayes & Gelso, 1993). Extending this finding to the realm of supervision, it was hypothesized that *supervisor* biphobia would predict *supervisor* CT toward the supervisee's bisexual clients, which would seemingly make supervisee CT more difficult to detect.

Supervisor biphobia may also be an important variable to investigate in its own right. It has not previously been studied, but other research documenting supervisor heterosexist bias and homophobia in supervision suggests that it may be important (Phillips & Fischer, 1998; Pilkington & Cantor, 1996; Buhrke, 1989; Buhrke & Douce, 1991; Murphy et al., 2002). Additionally, supervisees are less likely to make important disclosures in supervision when they judge the supervisor to be incompetent or biased (Ladany et al., 1996). Ineffective supervision may contribute to ineffective or harmful therapy, or in the case of bisexual clients, therapy that is not sensitive to the client's bisexual identity and special developmental and contextual concerns (Bernard & Goodyear, 1998; Eddy & Forney, 2000; Robin & Hamner, 2000). In the long run, poor or inadequate supervision of trainees working with bisexual clients (and LGB individuals in

general) may lead to a new generation of professionals who are poorly trained to work with such clients (Phillips & Fischer, 1998). Therefore, it is important to find ways to ensure the effectiveness of supervision in preparing trainees to work with LGB clients.

No previous research has investigated how supervisor attitudes and supervisor CT reactions toward a supervisee's client relate to supervisor ability to detect supervisee CT behavior toward the client. Nor has research examined how this might apply specifically to supervision of therapy with bisexual clients, a population likely to elicit CT reactions in both supervisor and supervisee and relatedly, a population that poses special training and supervision needs for trainees. Thus, the purpose of the present study was to examine how both 1) supervisor attitudes toward bisexuality (biphobia) and 2) supervisor CT reactions toward a supervisee's bisexual client relate to supervisor ability to detect a supervisee's CT reaction to a bisexual client accurately. An analogue methodology was used to address these purposes. The present study may add to our understanding of the process of CT management via supervision, a process that is important to both supervisee training as well as client treatment outcome. Additionally, this study was intended to provide insight into a specific way in which training with LGB clients may be lacking, thus offering implications for how training can be improved.

Chapter 2

Review of the Literature

The present study examined the relationships among supervisor biphobia, supervisor countertransference (to a supervisee's bisexual client), and supervisor ability to detect supervisee countertransference reactions to a bisexual client. No study to date has investigated supervisors' ability to detect countertransference (CT) in supervisees, even though supervision is a primary modality for managing CT (Williams et al., 1997; Ladany et al., 1997). Supervision can also be viewed more broadly as a component of therapist training and preparation of the next generation of professionals (Bernard & Goodyear, 1998). Research indicates that counselor training may still need improvement in preparing trainees to work with sexual minority populations (e.g., Phillips & Fischer, 1998; Phillips, 2000; Buhrke & Douce, 1991). Most of this research has focused on counseling and training issues relevant to lesbians and gays, often overlooking how the issues apply to bisexuals or generalizing the findings to bisexuals with the assumption that their experiences are the same as lesbians and gays (e.g., Phillips, Ingram, Smith, & Mindes, 2003; Bieschke, McClanahan et al., 2000; Fox, 1996). While bisexuals do share some common issues with lesbians and gays, they also face certain psychosocial stressors unique to being bisexual (Firestein, 1996; Fox, 1995; Ochs, 1996; Robin & Hamner, 2000). Thus, more research is needed on counseling and training issues specific to bisexual populations (Phillips & Fischer, 1998).

In this literature review, I first discuss counseling issues relevant to LGB clients in general and bisexual clients specifically. Next, I specifically focus on the counseling issue of CT and its impact on counseling sexual minority clients. I then discuss the

management of CT via supervision. Finally, I will discuss supervision as a mode of training for clinical work with sexual minority clients, highlighting the documented need for improved graduate training in this area (e.g., Phillips & Fischer, 1998).

Counseling Issues with LGB Clients

Despite the declassification of homosexuality as a mental illness by the American Psychiatric Association in 1973 and the American Psychological Association in 1975, many therapists still operate with the belief that LGB individuals are in some way pathological, disordered, or at least deviant (Garnets et al., 1991; Liddle, 1996; Graham et al., 1984). While empirical evidence has demonstrated that sexual minority identity does not in itself imply mental illness, sexual minority individuals are at elevated risk for mental disorders because of the stresses inherent to being a stigmatized minority (Hooker, 1957; Cochran et al., 2003; Meyer, 2003). Research has also demonstrated that sexual minority individuals utilize psychological services at a higher rate than heterosexual individuals (Cochran et al., 2003; Liddle, 1996), and that most psychologists have worked with or currently work with sexual minority clients (Garnets et al., 1991; Hancock, 1995; Graham et al., 1984). Nevertheless, it appears that sexual minority individuals still have difficulty obtaining counseling that is helpful and affirmative (Liddle, 1996, 1997; Garnets et al., 1991). Numerous studies document the continued existence of heterosexist bias, lack of knowledge of issues specific to sexual minority individuals, and unhelpful/harmful practices among mental health professionals and graduate trainees (e.g., Liddle, 1996; Garnets et al., 1991; Pilkington & Cantor, 1996; Glenn & Russell, 1986; Murphy et al., 2002; Phillips & Fischer, 1998).

While there has been an abundance of research in the past 30 years intended to

enhance the effectiveness of psychotherapy with lesbian and gay male clients, comparatively little research has been conducted on what constitutes effective practice with bisexual clients (e.g., Fox, 1996; Phillips et al., 2003; Bieschke, McClanahan, et al., 2000; Buhrke et al., 1992). In a comprehensive review of the literature in six major counseling journals from 1978 to 1989, the number of articles on bisexuality was zero (Buhrke et al., 1992). Bisexual clients have often been assumed to have the same experiences and issues as homosexual clients, given their common status as sexual minorities (Betz, 1991; Fox, 1996). In many studies, they have been either grouped with lesbians and gays, or grouped as heterosexual or homosexual depending on the gender of their partners (opposite-sex or same-sex) (Fox, 1996; Bieschke, McClanahan, et al., 2000). It has only recently been acknowledged that counselors may need special training and knowledge to work competently with bisexual clients, differing in some respects from the training and knowledge that informs their work with lesbian and gay clients (e.g., Phillips & Fischer, 1998; Phillips, 2000; Guidry, 1999; Matteson, 1996).

Competency with LGB clients may be conceptualized according the attitudes, knowledge, and skills framework of multicultural competency (Atkinson, Morten, & Sue, 1983; Fassinger, 1991). If counselors are to be effective in working with LGB clients, they must explore and challenge their heterosexist biases (*attitudes*), develop a working knowledge of LGB issues (*knowledge*), and cultivate the use of appropriate and helpful practices with LGB clients (*skills*) (APA, 2000; Kocarek & Pelling, 2003). This section will examine attitudes, knowledge, and skills with respect to counseling LGB clients. In each area discussed in this section, issues specific to bisexual clients will be highlighted.

Counselor attitudes: Heterosexism, homophobia, and biphobia. Heterosexism is defined as a world-view or value system that values heterosexuality, assumes it is the only appropriate manifestation of love and sexuality, and devalues all that is not heterosexual (Herek, 1995). It has also been conceptualized as the institutional promotion of heterosexual life and the concurrent subordination of gay, lesbian, and bisexual experience (Ritter & Terndrup, 2002). By contrast, homophobia has been defined as an irrational fear of homosexuality (Bhugra, 1987) and may include a wide range of negative emotions, attitudes, and behaviors towards lesbians and gay men (Herek, 1995; Ritter & Terndrup, 2002). Similar in some respects to homophobia, biphobia refers to the general invalidation of bisexuality as an acceptable sexual orientation because of the belief that sexual orientation is dichotomous or fixed (Ochs, 1996). It may manifest itself as negative stereotyping of bisexuals, interpersonal fear or distrust of bisexuals, or other negative behaviors toward bisexuals such as violence, discrimination, or exclusion from the gay or heterosexual communities (Ochs, 1996; Guidry, 1999; Robin & Hamner, 2000).

Mohr and Rochlen (1999) have conceptualized biphobia as consisting of two components: Tolerance (the extent to which bisexuality is viewed as a tolerable, moral sexual orientation) and Stability (the extent to which bisexuality is seen as a legitimate, stable sexual orientation). They theorize that Tolerance represents the component of biphobia that is shared with homophobia, namely intolerance of same-sex relations in general. Stability represents the component of biphobia that is distinct from homophobia, the part of biphobia that is uniquely targeted at bisexuals. Stability taps into some of the negative stereotypes and stigma directed at bisexuals. For example, bisexual individuals

may suffer stigma for the violation of an arguably more fundamental societal norm than opposite-sex pairing: the dichotomy of sexuality (Queen, 1996). It is widely believed that sexual orientation consists of a primary sexual or affectional attraction to one gender or the other. Bisexuality does not fall neatly into this either-or categorization of sexual orientation (Queen, 1996; Firestein, 1996; Ochs, 1996; Guidry, 1999; Fox, 1995; Robin & Hamner, 2000).

Consequently, bisexual individuals may often have their experiences and feelings questioned and invalidated by members of both the heterosexual and gay communities (Mulick & Wright, 2002; Ochs, 1996; Firestein, 1996). They may be thought to be in denial of their true gay identity or in transition to coming out as gay. Members of the gay community especially may resent bisexuals. They may believe bisexuals have chosen bisexuality as a way of maintaining some degree of heterosexual privilege, or because they were too ashamed or cowardly to embrace a gay identity fully (Ochs, 1996).

Alternatively, bisexuals may be considered to be heterosexual but going through a phase of homosexual attraction that will eventually pass (Ochs, 1996; Fox, 1995, 1996; Guidry, 1999). While it is true that *some* individuals identify as bisexual prior to identifying as exclusively homosexual, and also true that many individuals have sexual attractions/experiences with members of both sexes at certain points in their lives, these two notions of bisexuality hardly account for the complexity of the bisexual identity (Queen, 1996; Diamond, 2000, 2003; Fox, 1995; Rust, 1996). Because of their different sexual and relationship patterns, bisexuals may also be viewed as experiencing immature, transitional, or developmentally arrested sexuality (Dworkin, 2000; Queen, 1996; Fox, 1995, 1996; Rust, 1996) or as having psychopathology (Ochs, 1996; Mohr et al., 2001).

Although society has arguably become more tolerant of sexual minorities in the past 30 years, heterosexism, homophobia, and biphobia still exist in both overt and subtle ways (Herek, 1995, 2002; Ochs, 1996; Fassinger, 1991; Meyer, 2003). Examples include the lack of legal recognition for same-sex partnerships in most states, assumptions of heterosexuality unless an individual specifies otherwise, or assumptions about one's sexual orientation based on the gender of one's partner, which precludes bisexual orientations (Ritter & Terndrup, 2002; Robin & Hamner, 2000; Guidry, 1999).

The impact of heterosexism, homophobia, and biphobia on the mental health and well-being of LGB individuals is well-documented (Ritter & Terndrup, 2002; Meyer, 2003; Cochran et al., 2003). A meta-analysis of studies on the prevalence of mental disorders in lesbians, gay men, and bisexuals found that LGB individuals do, in fact, have a higher prevalence of mental disorders than heterosexuals (Meyer, 2003). Meyer (2003) attributes this finding to "minority stress," explaining that stigma, prejudice, and discrimination create a hostile and stressful social environment that increases the likelihood of mental health problems. Using a nationally representative survey of 2917 midlife adults, Cochran et al. (2003) found that gay and bisexual men had a higher prevalence of depression, panic attacks, and psychological distress than heterosexual men. This makes sense given gender differences in heterosexism and homophobia. Specifically, men tend to have more homonegative attitudes than women, and attitudes toward gay and bisexual men are usually more negative than attitudes toward lesbian and bisexual women (e.g., Morrow, 2000; Herek, 1988; Kite & Whitley, 1996; Eliason, 2001). Herek (1995) asserts that heterosexism causes LGB people to stay closeted about their sexual identity, leading to feelings of isolation and a painful discrepancy between

their private and public lives. Moreover, heterosexism, homophobia, and biphobia may be internalized by LGB individuals, contributing to such problems as low self-esteem, depression, anxiety, and acting-out behaviors such as increased substance abuse among LGB individuals (e.g., Herek, 1995; Hancock, 1995; Ritter & Terndrup, 2002; Dworkin, 2000).

Some research has indicated that attitudes toward bisexuals may be more negative than attitudes toward lesbians and gays. Herek (2002) assessed heterosexual adults' attitudes toward bisexual men and women using data from a random sample (N = 1335). Ratings for bisexual men and bisexual women were lower than ratings for all other groups assessed (e.g., racial, ethnic, religious, and political groups) except for injecting drug users. Moreover, heterosexual women rated bisexuals less favorably than they rated lesbians or gay men. Some evidence also suggests that attitudes toward bisexual men may be particularly negative. In a study that examined the attitudes of heterosexual college students (N = 229) about bisexuality, Eliason (2001) found that bisexual men were rated more negatively than bisexual women, lesbians, or gay men.

Research suggests that mental health professionals are not immune to heterosexist attitudes (Bieschke et al., 2000). One survey of the literature on the attitudes of mental health professionals toward homosexuality found a number of interesting inconsistencies and contradictions (Rudolph, 1988). For example, the LGB-affirmative stance of professional organizations such as APA was often found to contradict with the attitudes and practices of individual therapists, who were conflicted in their attitudes (i.e., negative in some contexts and not others). Rudolph (1988) attributes the inconsistency in attitudes to the mixed messages received by mental health professionals. While being told on the

one hand by professional organizations that they must take an LGB-affirmative stance, they live in a society that is in many ways heterosexual. Buhrke and Douce (1991) assert that even professional organizations and training programs send mixed messages by being heterosexual in some respects and LGB-affirmative in others. Garnets et al. (1991) found that some therapists still viewed homosexuality as a form of mental illness or developmental arrest, automatically attributed clients' presenting problems to sexual orientation, or automatically assumed a client was heterosexual. Heterosexist biases have been documented in trainees (Glenn & Russell, 1986; Casas, Brady, & Ponterotto, 1983), training programs (e.g., Pilkington & Cantor, 1996), and mental health professionals (Graham et al., 1984; Garnets et al., 1991). Therapist heterosexist attitudes may even be communicated to clients indirectly or unconsciously in various ways, such as the use of heterosexist language or whether further exploration of certain topics is encouraged or avoided (McHenry & Johnson, 1993).

Despite this evidence of heterosexism among mental health professionals, more recent research suggests that attitudes toward LGB clients may be improving. For example, one survey of clinical and counseling psychology graduate students found that the vast majority had positive attitudes toward LGB people and issues (Phillips & Fischer, 1998). Moreover, in a review of the literature of therapist attitudes toward LGB clients, Bieschke et al. (2000) asserted that the attitudes of therapists are generally more positive than the attitudes of the general public toward LGB individuals and that the importance of LGB-affirmative therapy is becoming widely recognized.

Very little empirical research exists on biphobia in counselors, although one study indicated that bisexual clients perceive more heterosexist bias in their therapists than do

lesbian or gay male clients (Moss, 1995). Mohr, Israel, and Sedlacek (2001) found that biphobia, above and beyond homophobia, predicted negative anticipated reactions to working with a bisexual client, lower ratings of the client's functioning, beliefs that they would impose their personal values on the client, and a tendency to relate the client's presenting problems to bisexual stereotypes unnecessarily. Therapists with biphobic attitudes may hold negative stereotypes about bisexuals, may view bisexuality as developmental arrest or psychopathology, and may feel uncomfortable working with a bisexual client (Matteson, 1996; Fox, 1995, 1996; Guidry, 1999).

While therapist attitudes toward LGB clients are not uniformly or even predominantly negative by most accounts, the general consensus is that homophobic and biphobic attitudes predict negative reactions to lesbian/gay and bisexual clients, respectively (Phillips & Fischer, 1998; Hayes & Gelso, 1993; Gelso et al., 1995; Mohr et al., 2001). Conversely, positive attitudes toward lesbian, gay, and bisexual clients predict greater self-efficacy in trainees performing LGB affirmative counseling (Dillon & Worthington, 2003). Taken together, these findings suggest that training and interventions aimed at cultivating more LGB-affirmative attitudes may be an important means of increasing counselor effectiveness with LGB clients. Self-exploration of values, attitudes, and biases is crucial (Morrow 2000; APA, 2000).

Knowledge about LGB issues. In addition to examining and challenging negative attitudes toward LGB individuals, mental health professionals must cultivate a working knowledge of the major concerns and stressors faced by LGB individuals. To facilitate this knowledge, APA (2000) established a set of guidelines for psychotherapy with lesbian, gay, and bisexual clients, with the stated goals of providing psychologists with a

frame of reference and basic information pertaining to LGB counseling issues. Some of the issues that psychologists are encouraged to understand include: the coming-out process (and how it may be influenced by age, gender, ethnicity, race, disability, and religion), internalized oppression, human sexuality, same-sex relationship dynamics, family-of-origin relationships, special concerns of diverse LGB populations (youth, elderly, racial/ethnic minorities, disabled, etc.), LGB parenting issues, anti-LGB prejudice and violence, struggles with spirituality and religious group membership, career issues and workplace discrimination, and coping strategies for successful functioning (APA, 2000; D'Augelli & Patterson, 1995; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002; Fassinger, 1991).

In addition to issues common to all sexual minorities, bisexual individuals may also experience such concerns as lack of community and social isolation (lack of full acceptance by either the gay or straight communities), prejudice and lack of validation of their identity, concerns about relationships (i.e., difficulties finding partners that accept their identities, how to come out in existing relationships, negotiating non-traditional or polyamorous relationships), and difficulties coming out as bisexual if one previously came out as gay or lesbian (APA, 2000; Fox, 1995, 1996; Guidry, 1999; Robin & Hamner, 2000; Ochs, 1996; Firestein, 1996; Rust, 1996; Queen, 1996; Matteson, 1996). A full discussion of these many complex issues is beyond the scope of this paper. Because my study examined supervisee CT toward a bisexual male college student, I will discuss issues that are typical of the LGB college student population, with a focus on bisexuals.

It is important for counselors in college counseling centers to have an

understanding of developmental issues relevant to gay, lesbian, and bisexual college students. College often represents the formative time for developing a stable sexual identity (D'Augelli, 1992) and the most common time for first coming out and sexual experiences among LGB individuals (D'Augelli, 1991). Moreover, the process of developing one's sexual identity may add complexity to the already challenging developmental tasks confronted by college students (Eddy & Forney, 2000). Chickering and Reisser (1993) have theorized that college students must work through such developmental tasks as developing competence, managing emotions, moving through autonomy toward interdependence, developing mature interpersonal relationships, establishing identity, developing purpose, and developing integrity. The process of developing a sexual identity may compete with or overshadow these other developmental tasks (Eddy & Forney, 2000). Developmental tasks specific to the formation of a sexual minority identity may include coming out to oneself and others, readjusting one's concept of oneself as part of a stigmatized minority rather than the majority, seeking out and becoming involved with the LGB community, and resolving issues of self-esteem due to internalized homophobia or biphobia (e.g., Cass, 1979; McCarn & Fassinger, 1996).

As evidenced by its association with depression, anxiety, suicidality, somatic concerns, and substance abuse, the coming out process can be extremely stressful (Caitlin & Futterman, 1997; Smith, 1988; Hancock, 1995; Ritter & Terndrup, 2002). For example, coming out to others may involve a variety of risks, including the possible loss of important relationships or even the possibility of violent reprisal (Fassinger, 1991). Moreover, all of these developmental tasks must take place alongside other environmental demands and expectations (e.g., academic), and sometimes in the context

of a stressful environment (e.g., student does not feel safe coming out) (Eddy & Forney, 2000). In a comprehensive summary of the literature on LGB college student issues, Bieschke, Eberz, and Wilson (2000) reported that LGB college students are often victims of verbal harassment and abuse, physical assault, intimidation, discrimination, and marginalization in the college environment. Being harassed or victimized because of one's sexual orientation may lead to PTSD symptoms, anxiety over sexual identity or regression to an earlier state of the coming out process, internalized homophobia or biphobia, and difficulties with intimacy (Caitlin & Futterman, 1997; Hancock, 1995; Dworkin, 2000; D'Augelli, 1992). Given the complexity of these issues, it is not surprising that LGB college students may be seeking support through university counseling services. It is important that counselors understand LGB students' issues developmentally and contextually so that they do not pathologize these students.

Counselors may also need to be aware of issues unique to bisexual college students. In addition to the developmental tasks mentioned above, bisexuals may need to come to terms with not fitting neatly into the prescribed social categories of heterosexual, lesbian, and gay. Their developmental task of seeking out support and companionship from the sexual minority community may be complicated by the fact that the gay community (particularly the lesbian community) may stigmatize them. They may also be stigmatized by heterosexuals (Robin & Hamner, 2000; Ochs, 1996). Bisexual men, especially, may be seen as vectors carrying HIV from the gay to straight communities (Stokes, Taywaditep, Vanable, & McKirnan, 1996). Bisexual students may have their identities rendered invisible by beliefs that bisexuality is not a true sexual orientation and does not exist, or may be categorized as gay or straight depending on the gender of their

current partner (Firestein, 1996; Fox, 1995; Robin & Hamner, 2000; Guidry, 1999).

Because of the lack of validation of their identities and lack of community, bisexual identity development may differ in important ways from gay and lesbian identity development (Dworkin, 2000; Weinberg, Williams, & Pryor, 1994). Although research on bisexual identity development is only in its infancy compared to research on gay and lesbian identity development, some have suggested that bisexual identity development may be nonlinear, multifaceted, fluid, and often lacking in closure (Ritter & Terndrup, 2002; Dworkin, 2000; Fox, 1995). Weinberg et al. (1994) characterized bisexual identity development as consisting of initial confusion, finding and applying the label, settling into the identity, and continued uncertainty. In comparison to the fixed, positive, and community-identified gay or lesbian identity that characterizes the end point of most lesbian and gay identity models (e.g., Cass, 1979), “continued uncertainty” encompasses the ongoing difficulties bisexuals may experience as a result of prejudice and lack of validation of their identity, as well as ongoing relationship concerns related to their bisexuality. Some possible relationship concerns include coming out to partners as bisexual; renegotiating the meaning of a bisexual identity in long-term, monogamous relationships (opposite-sex or same-sex); and negotiating alternative relationship arrangements such as polyamory (Rust, 1996; Matteson, 1996). Empirical support for the “continued uncertainty” that bisexuals may experience is provided by a study of clinical psychologists, who reported that their bisexual clients struggled with identity development, felt pressure to “choose” either a heterosexual or gay identity, had personal doubts about whether their bisexuality was a developmental stage toward their “true” identity, and felt confused when they could not come to either a heterosexual or

gay/lesbian identity (Murphy et al., 2002). The need for therapist understanding of bisexual issues was underscored by the fact that therapists in this study reported having the same doubts about bisexuality as their struggling clients.

It has also been suggested that the bisexual identity development process may differ for men versus women (Dworkin, 2000). Fox (1995) found that bisexual women usually have heterosexual experiences before having a homosexual experience, while men experience homosexual attractions either before or at the same time as heterosexual attractions. Moreover, bisexuals often come out later than gays and lesbians, possibly due to the lack of support for bisexuals and the belief that sexual orientation is dichotomous (Dworkin, 2000; Firestein, 1996; Fox, 1995; Matteson, 1996). Although bisexual and gay men are stigmatized more overall than sexual minority women, bisexual women may be stigmatized more by the lesbian community than bisexual men are by the gay male community (Eliason, 2001; Matteson, 1996; Ochs, 1996; Morrow, 2000).

In sum, counselors must cultivate a working knowledge of issues relevant to lesbian, gay, and bisexual clients. However, in addition to knowledge, counselors must also learn and implement skills and appropriate practices for working with LGB clients.

Skills for working with LGB clients. Even though the official stance of professional mental health organizations toward homosexuality and bisexuality changed during the 1970's, sexual minorities continued to have difficulty finding helpful or affirmative therapists (Liddle, 1996, 1997; Garnets et al., 1991). In response to this problem, the APA Committee on Lesbian and Gay Concerns created a task force that investigated bias in psychotherapy with lesbians and gay men in a large (N = 2544) and diverse nationwide sample of psychologists. The survey asked psychologists to describe

incidents of especially harmful or especially helpful care with gay and lesbian clients (their own or other therapists'). It also inquired about what they thought constituted beneficial and harmful practices with gay and lesbian clients.

The results indicated that although most therapists (99%) had experience with gay and lesbian clients, not all therapists practiced in ways that are helpful to these clients. The survey found that 58% of respondents knew of negative incidents that occurred in therapy with gay or lesbian clients (Garnets et al., 1991). Some of the harmful practices identified by Garnets et al. (1991) included pathologizing homosexuality, focusing on sexual orientation unnecessarily as a therapeutic issue, trying to change the client's sexual orientation, trivializing or demeaning homosexuality, relying on the client to educate the therapist about sexual orientation issues, pressuring the client to come out to others (despite possible negative consequences), assuming the client was heterosexual, abruptly terminating the client without appropriate referral, underestimating the importance of intimate relationships and community, or conceptualizing the client's homosexuality as a phase.

The task force also identified a number of therapist practices that were seen as helpful, including: recognizing the impact of prejudice, discrimination, and internalized homophobia on presenting problems; helping the client overcome internalized homophobia; recognizing and validating the importance of same-sex relationships and alternative families in clients' lives; not assuming that client's homosexuality is a problem or related to presenting problems; examining the role of their own sexual orientation, attitudes, and biases on therapy; and taking necessary steps (i.e., consultation, increasing knowledge, appropriate referral) to resolve potential problems.

Liddle (1996) provided empirical support for the helpfulness and harmfulness of the practices identified by Garnets et al. (1991). She found that these practices were associated with lesbian and gay male clients' ratings of therapy helpfulness and treatment outcome in theoretically predicted ways. Specifically, harmful practices were associated with ratings of therapists as unhelpful and with poor treatment outcomes, while helpful practices were associated with positive therapist ratings and treatment outcomes. Moreover, therapist practices accounted for more variance in ratings of therapist helpfulness than did therapist sexual orientation. This finding is important, because therapist practices, unlike therapist demographic characteristics such as sexual orientation, can be taught and learned.

Fassinger (1991) also identified a number of practices that may contribute to LGB-affirmative therapy. Some of these include: becoming comfortable with one's own sexuality, encouraging clients to establish an LGB support system and being knowledgeable about appropriate resources to create such a system, helping clients become aware of how oppression affects them, being encouraging and approving with clients regarding their LGB identities and experiences in order to combat internalized homophobia, examining the interaction of LGB identity with other kinds of diversity, dealing with treatment of substance abuse issues common on this population, familiarizing oneself with issues related to AIDS and death/dying, and paying particular attention to ethical issues around confidentiality (Clark, 1987; Fassinger, 1991).

In regard to helpful practices for working with LGB college students, counselors should remember that the process of sexual identity development may be occurring alongside other important developmental tasks, in potentially unsupportive or unsafe

environments (Eddy & Forney, 2000). Counselors should not mistake the stress and confusion of coming out as psychopathology (e.g., identity confusion or borderline qualities) (Buhrke & Douce, 1991; Dworkin, 2000). Nor should counselors interpret a client's distress over sexual orientation as meaning that he or she is confused or needs help becoming heterosexual (Dworkin, 2000). Rather, it may be a legitimate response to societal and internalized homophobia/ biphobia or the stress of coming out (Buhrke & Douce, 1991; Herek, 1995; Meyer, 2003; Ritter & Terndrup, 2002; Caitlin & Futterman, 1997). Regarding bisexual clients, Robin and Hamner (2000) warn that it is important for counselors not to make assumptions about a client's sexual orientation on the basis of current romantic or sexual partners. Counselors should not assume that bisexuals have the same needs as lesbian and gay clients; bisexual clients vary in their degree of alliance/identification with the gay community. Nor should counselors assume that bisexual clients fit bisexual stereotypes (Guidry, 1999; Matteson, 1996). Although development of sexual identity may take place alongside other developmental tasks such as the capacity for intimacy, counselors should not view bisexuality as evidence of developmental arrest, immature sexuality, or problems with intimacy (Rust, 1996; Queen, 1996). While for some clients bisexuality may be transitional or part of a larger problem of identity diffusion, this is certainly not always the case (Fox, 1995; Diamond, 2000, 2003). Counselors must remember that bisexual clients vary in their level of identity development and relationship/ sexual patterns (Guidry, 1999; Matteson, 1996; Robin & Hamner, 2000).

Counselor competency with LGB clients may be thought of as a composite of attitudes, knowledge, and skills (Fassinger, 1991; Atkinson et al., 1983; Kocarek &

Pelling, 2003). One factor that may detract from counselor competency with LGB clients at any of these levels is unresolved issues in the counselor (e.g., McHenry & Johnson, 1993). For example, unresolved issues may contribute to negative counselor attitudes (homophobia or biphobia) (e.g., Graham et al., 1984), conceptualizing clients according to negative stereotypes rather than knowledge of relevant psychosocial issues (Mohr et al., 2001; Garnets et al., 1991), or using practices that are unhelpful to LGB clients (e.g., Liddle, 1996; Garnets et al., 1991; Gelso et al., 1995; Hayes & Gelso, 1993). Therapists may have unresolved issues regarding homosexuality, bisexuality, sexuality in general, their own sexual orientation, and gender roles (Herek, 1995; Morrow, 2000; Guidry, 1999; Queen, 1996; McHenry & Johnson, 1993). Such unresolved issues in the counselor can manifest themselves as CT reactions toward LGB clients (Gelso et al., 1995; Hayes & Gelso, 1993). The next section provides an overview of countertransference, as well as a review of some ways that CT can influence therapy with LGB clients.

Countertransference

In this section, I will first give an overview of the history of the concept of countertransference, controversy over its definition, and a structural theory of countertransference. I will then examine ways in which CT can be both helpful and harmful, related to the issue of CT management. I will also look at CT as it occurs in therapy with sexual minority clients.

History and definitions. The concept of CT was first introduced by Freud (1910/1959), who thought it involved the therapist's unresolved unconscious conflicts getting in the way of his objectivity. It was viewed as a hindrance to effective therapy, as something that must be overcome. For this reason, it received little research attention for

many years (Gelso & Hayes, 2002). New conceptions of CT emerged around the 1950's, about the same time the topic began to be studied empirically (e.g., Cutler, 1958). In addition to the use of analogue studies that have simplified investigation of this complex construct, CT has increasingly been viewed as present in all therapy relationships and potentially beneficial to treatment depending on how it is used (Gelso & Hayes, 2001, 2002).

While CT has been variously defined over the years, three definitions have been most prominent. The classical definition, similar to Freud's (1910/1959) original conception of countertransference, views CT as the therapist's unconscious, conflict-based reaction to the patient's transference. It creates distortions in the therapist that may lead the therapist to "act out," to the detriment of the therapy. To prevent CT reactions, therapists must work through their unresolved issues and conflicts (Gelso & Hayes, 2002). A second definition of countertransference, the totalistic definition, emerged in the 1950's and views CT as all of the therapist's emotional reactions to the patient (Heimann, 1950). This conception views CT reactions as potentially beneficial to therapy if they are used to help the therapist better understand the patient. Criticisms of the totalistic conception have generally focused on its being too broad and inclusive to be scientifically meaningful (Watkins, 1985). The third definition of CT is integrative. Countertransference includes the internal and external reactions of the therapist, derived from his or her own conflicts and needs, in response to both transference and nontransference client material (Gelso & Hayes, 2002; Gelso & Carter, 1994). By this conception, CT reactions are present in all therapy, and can be used to understand client dynamics. This definition is like the classical definition in that CT reactions may arise

from therapists' unresolved conflicts. It differs from the classical definition and is similar to the totalistic definition in that CT reactions can be either harmful or helpful to therapy, depending on whether they are acted out or used to understand the client better (Gelso & Hayes, 2001; Gelso & Carter, 1985, 1994; Hayes et al., 1997; Hayes et al., 1998; Rosenberger & Hayes, 2002).

Gelso and Carter (1985, 1994) assert that when defined from the integrative perspective, CT is a universal phenomenon. Empirical research thus far has supported this assertion. For example, a qualitative investigation of eight experienced therapists found that CT was present in 80% of their 127 sessions (Hayes et al., 1998). The present investigation defines CT from the integrative perspective.

Structural theory of countertransference. Countertransference has been theorized to consist of 5 components: origins, triggers, manifestations, effects, and management factors (Hayes, 1995). I will review these here and relate each of these to the present study.

Origins refer to therapists' areas of unresolved intrapsychic conflict (Hayes, 1995; Hayes et al., 1998). By virtue of being human, all therapists have issues that are unresolved to some degree. While these issues can benefit therapy by enhancing therapist empathy with the client (Gorkin, 1987; Peabody & Gelso, 1982), they can also harm therapy by eliciting distortions or defenses on the part of the therapist (e.g., Cutler, 1958; Gelso et al., 1995). Hayes et al. (1998) found several categories of origins of therapist countertransference, including family issues and therapist needs (e.g., need to be in control, need to be needed, need to be a good therapist, etc.). Related to the present study, research has shown that therapist homophobia predicts CT reactions to lesbian (Gelso et

al., 1995) and gay male clients (Hayes & Gelso, 1993). In the present investigation, biphobia (or unresolved issues around bisexuality and bisexuals) was the origin of interest. It was predicted that origins (i.e., biphobia) in the supervisor would relate to supervisor CT toward a supervisee's bisexual client, with consequent difficulties in detecting the supervisee's CT toward the client.

Triggers refer to therapy events that touch on a therapist's unresolved issues. Triggers may also include client characteristics, presenting problems, and behaviors/dynamics (Hayes, 1995; Hayes et al., 1998). The triggers most frequently investigated in previous research have been presenting problems and presenting interpersonal style. For example, therapist CT reactions have been demonstrated towards clients presenting with same sex relationship issues (Gelso et al., 1995; Hayes & Gelso, 1993), HIV infection (Hayes & Gelso, 1993), and rape (Latts & Gelso, 1995), as well as seductive (Peabody & Gelso, 1982), hostile (Hayes & Gelso, 1991), and angry (Sharkin & Gelso, 1993; Harbin, 2004) clients. These findings have yielded mixed or unexpected results that have called into question the value of triggers alone in predicting CT reactions. For example, therapists did not, as predicted, exhibit more CT overall toward lesbian (Gelso et al., 1995) or gay male (Hayes & Gelso, 1993) than they did toward heterosexual clients. However, in both studies, *homophobic* therapists did experience more CT toward lesbian/gay clients than heterosexual clients. The overall conclusion of this line of research is that the interaction of triggers and origins, rather than triggers alone, predict therapist CT reactions (Rosenberger & Hayes, 2002; Sharkin & Gelso, 1993; Hayes & Gelso, 1993; Gelso et al., 1995). In the present study, the trigger of interest was the client's bisexuality. It was predicted that the interplay of origin and

trigger (i.e., the supervisor's biphobia and the client's bisexuality) would predict a CT reaction on the part of the supervisor.

Manifestations refer to therapist behaviors, thoughts, or feelings that result when the therapist's unresolved issues are evoked (Hayes, 1995). These reactions can be divided into two categories: internal and external. Internally, CT reactions can be experienced affectively as increased state-anxiety (e.g., Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993) and cognitively as distortions of client material (i.e., inaccurate recall of client material; Cutler, 1958, Gelso et al., 1995; Hayes & Gelso, 1993). Externally, CT reactions can be manifested behaviorally as avoidance or withdrawal from the client (Bandura et al., 1960; Hayes & Gelso, 1993) or overinvolvement with the client (Gelso et al., 1995). The present study only assessed the internal CT reactions of supervisors (i.e. affective and cognitive CT) because supervisors did not have the opportunity to manifest behavioral CT. Supervisors did, however, observe their supervisee's behavioral CT in the analogue therapy session they heard. Hence, each type of CT will be reviewed here briefly.

Cognitive CT reactions are often assessed as the therapist's inaccuracy of recall of client material. The rationale behind this operationalization is that therapists tend to be less accurate at recalling client material that touches on their unresolved issues. In other words, when therapists experience CT, they tend to distort client material and thus remember it less accurately (Cutler, 1958; Gelso et al., 1995). Cutler (1958) found that therapists either over- or under-reported clients' behavior when clients talked about issues that were unresolved for the therapist. Gelso et al. (1995) also found that therapists experiencing CT reactionstended to have distorted recall of client material. Specifically,

they found that female therapists had more difficulty than male therapists recalling sexual material discussed by a lesbian client, whereas male and female therapists had equivalent recall with a heterosexual client discussing similar issues. The interpretation of this finding was that the sexual material discussed by the lesbian client tapped into the unresolved issues of the female therapists. The utility of the cognitive assessment of CT is that it is not subject to social desirability. For example, therapists can try to be “politically correct” and disguise their CT reactions toward a sexual minority client when it is assessed via other methods. But they cannot disguise a cognitive CT reaction, which asks them to recall the number of words used by the client on a certain conflictual topic, because they have no way of knowing the actual number of words used. In the present investigation, supervisor cognitive CT was assessed as the accuracy of the supervisor’s recall of sexual words or phrases used by the supervisee’s bisexual client.

Affective CT reactions have typically been operationalized as therapist state-anxiety evoked by client material (Gelso et al, 1995; Hayes & Gelso, 1991, 1993; Sharkin & Gelso, 1993). The rationale behind this measure is that therapists are likely to experience heightened anxiety when client material taps into their unresolved issues (Singer & Luborsky, 1977). Empirical research has supported this proposition. For example, Sharkin and Gelso (1993) found that therapists who had unresolved issues around anger were more likely to experience discomfort and anxiety with an angry client. Hayes and Gelso (1993) found that therapists experienced greater anxiety with an HIV-positive client than with an HIV-negative client. The present study assessed supervisor state-anxiety via methods similar to those used in the above studies (i.e., the STAI; Spielberger, Gorsuch, & Lushene, 1970). Our prediction was based on the findings of the

studies mentioned above; namely, we predicted that supervisors with unresolved issues around bisexuality would experience heightened state-anxiety when listening to a supervisee's session with a bisexual client.

Behavioral CT has traditionally been conceptualized as counselor avoidance of threatening client material (Bandura et al., 1960). For example, therapist homophobia predicted verbal avoidance responses to gay male clients (Hayes & Gelso, 1993). Gelso et al. (1995) hypothesized that CT behavior could be manifested through either avoidance of or overinvolvement with conflictual material. They did not find conclusive evidence for overinvolvement. A more recent conceptualization of behavioral CT has been positive versus negative CT behavior (Friedman & Gelso, 2000). Positive CT is therapist behavior that seems supportive, but in an unhealthy, dependent, or enmeshed way. Negative CT is therapist behavior that seems rejecting, avoidant, or dismissive. Both types of CT can be harmful to therapy process and outcome, because in both cases therapists are acting out their own needs and conflicts rather than responding to the needs of the client (e.g., Hayes et al., 1997).

Effects refer to the ways in which CT manifestations impact therapy process and outcome (Hayes, 1995; Hayes et al., 1998). Therapy process and outcome was not assessed directly in the present investigation. However, in our investigation, supervisor participants listened to a session in which a supervisee acted out his CT reaction behaviorally, rather than managing it. Thus, supervisors had the opportunity to observe the effect of the supervisee's CT on the process and outcome of a single session. Although we did not ask them to rate session process or outcome, we did ask them to rate therapist CT behaviors theorized to have a negative impact on therapy process and

outcome (e.g., rejecting the client; Friedman & Gelso, 2000). Empirical research has also demonstrated the negative impact of CT behavior on therapy process and outcome. For example, Cutler (1958) found that when client material touched on therapist unresolved conflicts, therapists were more likely to use interventions judged by their supervisors to have been inadequate. Ligiero and Gelso (2002) found a negative relationship between CT behavior and the working alliance between therapist and client. In a study of 20 cases of brief therapy, Hayes et al. (1997) found that in less successful cases, a strong negative relationship existed between CT behavior and outcome, as rated by therapists, clients, and supervisors. Finally, it has been demonstrated that CT management ability (indicative of less CT behavior) was positively related to treatment outcome ratings (Gelso et al., 2002; Friedman & Gelso, 2000). Taken together, these findings support the assertion that CT behavior, if unmanaged and acted out, can have a negative impact on therapy. Countertransference can also have a positive impact on therapy if managed and used to deepen insight into client dynamics (Hayes et al., 1998). The issue of CT management is discussed next.

Management factors refer to therapist behaviors and characteristics that help therapists regulate and productively use their CT reactions. These factors, in addition to decreasing the likelihood of acting out CT behavior, can help therapists use their CT reactions beneficially once they have occurred and can improve the working alliance (Hayes, 1995; Friedman & Gelso, 2000; Hayes et al., 1998; Rosenberger & Hayes, 2002; Gelso et al., 2002; Ligiero & Gelso, 2002). Hayes (1995) suggested several methods of managing CT, including supervision, personal therapy, reflecting on sessions, and meeting one's personal needs outside of work so that they do not interfere with

conducting therapy. Therapist factors that contribute to CT management ability include self-insight, anxiety management, conceptual skills, self-integration, and empathy (Hayes, Gelso, VanWagoner, & Diemer, 1991; VanWagoner et al., 1991; Latts & Gelso, 1995; Gelso et al., 2002). *Self-insight* refers to therapists' awareness of their feelings and the causes of their feelings. *Anxiety management* refers to how well therapists are able to control their anxiety. *Conceptual skills* refer to therapists' ability to conceptualize their clients' dynamics within the therapy relationship. *Self integration* assesses therapists' understanding of the boundaries between themselves and their clients. Finally, *empathy* refers to therapists' ability to understand their clients on an emotional and intellectual level (Hayes et al., 1991; VanWagoner et al., 1991). Taken together, these five factors aid therapists in controlling their CT reactions to clients, so that they are not acted out to the detriment of therapy process and outcome. Hayes and Gelso (2001) have noted that most CT research has looked at ways in which CT can hinder therapy, and they argue that more research should be devoted to understanding how therapists can use their CT to benefit their work and clients (i.e., via CT management). Countertransference management relates to the present investigation in that CT management often occurs via supervision (Hayes, 1995; Bernard & Goodyear, 1998; Ladany et al., 1997; Ladany et al., 1996; Long, 1996; Williams et al., 1997). The issue of CT management via supervision will be discussed in more detail in the supervision section of this literature review.

Countertransference with sexual minority clients. Countertransference with sexual minority clients has been addressed in the literature both theoretically and empirically. Theoretical assertions will be reviewed first, followed by a review of empirical studies.

Theoretical assertions have generally focused on the difficulties created by CT

toward a sexual minority client, rather than the potentially useful ways it can be used. For example, several researchers have theorized that CT issues may arise between a heterosexual therapist and a sexual minority client as a result of the therapist's guilt or the client's resentment over heterosexual privilege (Gelso & Mohr, 2001; Greene, 1994; Morrow 2000). For example, Buhrke and Douce (1991) have identified how difficult it may be for beginning trainees to work with the difficult emotions and issues presented by LGB clients, such as anger or resentment over rejection by family. The result may be that the working alliance is initially more difficult to develop (Gelso & Mohr, 2001). Alternately, the therapist may find herself overcompensating or "bending over backward" with these clients while failing to set appropriate limits, or placing too much blame on societal causes of the client's distress while failing to recognize the client's personal contributions (Greene, 1994). Some therapists might try to overemphasize either similarities or differences between LGB individuals/relationships and heterosexual individuals/relationships. In either direction, this overemphasis represents a distortion. Another distortion might occur when therapists assume a client is overly similar to other LGB individuals the therapist has met, particularly when the therapist has had very little contact with LGB individuals (Morrow, 2000).

Others have theorized that CT plays out in ways that are more rejecting or dismissive to the sexual minority client. Homophobic therapists may collude with clients' internalized homophobia because the issue is uncomfortable and emotionally charged for both (McHenry & Johnson, 1993). The result is that clients remain stuck and do not effectively work through their issues. For example, therapists may collude with clients' uncertainty about sexual orientation during the coming-out process by suggesting their

homosexuality is experimental or a phase. Other forms of CT might include denial of the oppressions faced by LGB clients, failure to challenge negative stereotypes about LGB people, or even pathologizing LGB clients by blaming them for problems that are the result of societal oppression and marginalization (McHenry & Johnson, 1993; Greene, 1994; Long, 1996). Therapists may also experience CT to a same-sex client's erotic transference. Their discomfort may lead them to ignore the transference. This response may seem rejecting and does not allow the client to work through the transference (Morrow, 2000).

Some CT manifestations specific to bisexual clients have also been theorized. For example, when working with bisexual clients, therapists may define the clients' opposite-sex experiences as their preference, while labeling same-sex experiences as experimental (McHenry & Johnson, 1993). They may reward clients for behaviors that mimic the therapist's sexual orientation (e.g., heterosexual therapists may be more supportive of opposite-sex relationships, while gay/lesbian therapists may be more supportive of same-sex relationships). Therapists may also experience CT toward a bisexual client because bisexuality challenges their view of sexual orientation as fixed and dichotomous (Ochs, 1996; Queen, 1996; Morrow, 2000). Such a challenge might be threatening because it could bring up previously unexamined issues about the therapist's own sexual orientation (Morrow, 2000). Another possibility is CT toward alternative relationship forms pursued by some bisexuals (e.g., polyamory), manifested by the therapist's conscious or unconscious push for the client to be monogamous (Rust 1996).

Overall, it seems that these theoretical manifestations of CT toward sexual minority clients can be categorized as either positive or negative in valence (Friedman &

Gelso, 2000). Some forms seem to be overly supportive (e.g. overcompensation due to therapist guilt over privilege), while others seem rejecting, dismissive, or invalidating (e.g., pathologizing client). All of the manifestations represent distortions on the part of the clinician, leading to responses that are driven more by the clinician's internal conflicts than by the client's needs.

I now turn to empirical research addressing the issue of CT toward sexual minority clients. Several studies have investigated this issue directly, and will be reviewed here. The overall conclusion of these studies is that negative attitudes toward sexual minorities (i.e., homophobia) predict CT reactions toward sexual minority clients.

Hayes and Gelso (1993) investigated male counselors' reactions to gay and HIV-positive male clients in light of counselors' homophobia and death anxiety. Thirty-four counselors (both doctoral trainees and psychologists) watched a videotaped male client in one of 4 randomly assigned conditions: gay or straight, HIV-positive or HIV-negative. Thus, the independent variables in the study were client sexual orientation and client HIV status. The dependent variable was counselor discomfort (i.e., CT), assessed at the cognitive, affective, and behavioral levels. Cognitive CT was measured as the accuracy of counselors' recall of the number of words used by the client related to sexuality and death, with under- or over-recall indicating a CT reaction. Affective CT was operationalized as increased state anxiety. Behavioral CT was operationalized as the ratio of avoidance to approach verbal responses to the material presented by the taped client. Higher ratios of avoidant responses were thought to represent a behavioral CT reaction.

It was hypothesized that counselors would experience more discomfort (CT) with a gay client than with a heterosexual client, and also that homophobia would better

predict discomfort with a gay client than with a heterosexual client. The first hypothesis was surprisingly not supported; counselors did not experience more discomfort with the gay client than with the heterosexual client. This was attributed to the overall low level of homophobia in the sample. The second hypothesis was supported; specifically, counselor homophobia predicted increased verbal avoidance behavior with the gay client. In other words, male counselor homophobia predicted CT (at the behavioral level) toward a gay male client. One limitation of this study is that it did not allow for the examination of the effect of gender on the relationship between homophobia and CT, as only male participants were used. Secondly, in terms of generalizations that can be made to sexual minority clients, this study only looked at gay male clients; thus, we might wonder whether or not this relationship would apply to other categories of sexual minorities. These concerns were addressed by the Gelso et al. (1995) study, discussed next.

Gelso et al. (1995) replicated and extended the Hayes and Gelso (1993) study by looking at CT reactions to a lesbian client as a function of homophobia and counselor gender. Sixty-eight male and female counselor trainees viewed a videotaped client actress in 1 of 2 randomly assigned conditions: lesbian or heterosexual. In both conditions, the client discussed sexual issues in the context of a stable relationship; the material was identical across conditions, with variations in the gender of the partner mentioned by the client. Thus, this experiment had two independent variables: client sexual orientation and counselor gender. The dependent variable in this study was CT, assessed at the behavioral, cognitive, and affective levels. Cognitive recall was operationalized as accuracy of counselor recall of the number of sexual words used by the client; behavioral and affective CT were assessed in ways similar to the Hayes and Gelso (1993) study.

Several interesting findings emerged from the Gelso et al. (1995) study. First, like the Hayes and Gelso (1993) study, counselors did not experience more CT overall with the lesbian client than they did with the heterosexual client. The finding was interpreted in light of the very low homophobia in the samples of both studies. A second finding of the Gelso et al. (1995) study, also consistent with the Hayes and Gelso (1993) study, was that counselor homophobia was predictive of CT toward a lesbian client at the behavioral level. That is, counselor homophobia predicted a counselor tendency to use avoidant responses toward a lesbian client exploring sexual difficulties with her partner. A third finding of the Gelso et al. (1995) study was a significant interaction between gender and client sexual orientation, though only on the cognitive recall measure. Specifically, female counselors had greater recall difficulties than male counselors with the lesbian client, while female and male counselors did not differ in recall ability with the heterosexual client. This finding is noteworthy, given that the cognitive recall measure, unlike the other CT assessments, is not sensitive to social desirability. It suggests that CT toward sexual minority clients may be stronger in same-sex dyads, which is one reason why a male counselor-male client dyad was chosen for the present investigation.

The findings of both the Hayes and Gelso (1993) and Gelso et al. (1995) studies must be interpreted with some caution in light of the limits to external validity inherent in their analogue designs (Gelso, 1979). Because some of the results of these studies were unexpected (i.e., no differences found between CT reactions toward sexual minority and heterosexual clients) and inconsistent with other literature suggesting negative therapist attitudes toward sexual minorities clients (e.g., Garnets et al., 1991), counselors may not have reacted in this analogue as they would in real life sessions with real clients.

Nevertheless, taken together, these studies provide empirical support for the relationship between homophobia and CT reactions toward gay and lesbian clients, respectively. To date, no such parallel study exists on the relationship between biphobia and CT reactions toward bisexual clients. However, one study examined the relationship between biphobia and *anticipated* negative reactions (rather than CT) toward a bisexual client, and found results consistent with the Hayes and Gelso (1993) and Gelso et al. (1995) studies (Mohr et al., 2001).

In the Mohr et al. (2001) study, ninety-seven counselor trainees read a fictitious intake report about a bisexual woman seeking services at a university counseling center with several presenting problems, including career indecision, romantic relationships, and separation-individuation from family. Participants rated their anticipated reactions to clinical work with the client, the degree to which they believed they would impose their beliefs on the client, the client's overall level of psychological functioning, and the relatedness of the client's presenting problems to a variety of issues, some of which were bisexual stereotypes unrelated to the client's presenting problem .

The researchers hypothesized that counselor biphobia would predict negative anticipated reactions to working with the client, lower ratings of the client's psychosocial functioning, stronger beliefs that they would impose their personal values on the client, and a greater tendency to relate the client's presenting problems to bisexual stereotypes unnecessarily. The researchers also hypothesized that counselor biphobia would predict these reactions above and beyond counselor homophobia. All of these hypotheses were supported. Thus, although this study does not directly address the relationship between counselor biphobia and CT toward bisexual clients, it demonstrates that counselor

biphobia predicts *anticipated* reactions in counselors that seem similar to CT reactions. For example, an anticipated negative reaction toward a bisexual client might translate into a CT reaction when working with such a client. Unresolved issues about bisexuality might translate into counselors' tendency to pathologize a bisexual client (e.g., relate presenting problems to bisexual stereotypes, rate the client low in psychosocial functioning) or to impose their values and beliefs on the client in actual therapy work. However, no existing study looks at the relationship between biphobia and CT toward bisexual clients in an AV analogue, parallel to the Hayes and Gelso (1993) and Gelso et al. (1995) studies on gay male and lesbian clients. The present study proposed to fill this gap, and also to extend these three studies to the realm of supervision.

It is apparent from theory and empirical research that CT toward sexual minority clients can have a detrimental impact on therapy if not properly managed (e.g., Gelso et al., 1995; Hayes & Gelso, 1993; Gelso & Mohr, 2001; McHenry & Johnson, 1993). Iasenza (1989) asserted that it is important for trainees to manage CT towards sexuality minority clients, so that it is clear whether homophobia (biphobia) is emanating from the trainee, from the sexual minority client, or from both. Management of their CT can prevent distortions and acting out behaviors (Gelso et al., 2002; Friedman & Gelso, 2000; Gelso & Hayes, 2001, 2002). One place where trainees are likely to manage their CT reactions is in supervision (Bernard & Goodyear, 1998). In the next section, I give an overview of supervision and highlight supervisee and supervisor factors that can impede CT management in supervision, particularly with respect to sexual minority clients.

Supervision

Bernard and Goodyear (1998) offer the following definition of supervision:

“An intervention provided by a more senior member of a profession to...more junior members of that same profession. The relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to... client(s), and serving as a gatekeeper to those who are to enter the profession” (p. 6).

The overall goals and purposes of supervision follow from this definition. The two most fundamental goals of supervision are 1) to enhance the professional functioning of the supervisee, and 2) to monitor client care. In the interest of enhancing professional functioning, supervisors work to build supervisees' counseling skills and competencies (e.g., therapeutic techniques, case conceptualization, treatment planning, competencies specific to particular types of clients and presenting problems) (Bernard & Goodyear, 1998; Constantine, 1997). They also help to develop supervisees' professional identity. Because of the professional socialization role of supervision, supervisors must act as role models to supervisees (Bernard & Goodyear, 1998).

The second fundamental goal of supervision is monitoring client care. In addition to ethical concerns about the standard of care received by clients working with trainees, supervisors can also be held vicariously responsible for any harm done by the supervisee under supervision (Vasquez, 1992; Harrar, VandeCreek, & Knapp, 1990). When the goals of supervisee training and monitoring client care conflict, client welfare must be upheld above all else. For example, a supervisee judged as incompetent or as too impaired to see clients might have to stop seeing clients until rehabilitated, or in the worst case, prohibited from entering the profession (Vasquez, 1992; Bernard & Goodyear, 1998). This highlights the evaluative and gate-keeping functions of supervision.

Evaluation of supervisee progress and competency is necessary if supervisors are to fulfill their responsibility of safeguarding client welfare, both those currently seen by the supervisee and those who would be seen in the future if the supervisee were to enter the profession (Bernard & Goodyear, 1998).

Supervision is also important because of its relationship to therapy process and outcome for the supervisee (Patton & Kivlighan, 1997; Holloway & Neufeldt, 1995). Patton and Kivlighan (1997) found that trainees' perceptions of the supervisory working alliance were positively related to their clients' perceptions of the counseling working alliance and to aspects of treatment adherence. A positive supervisory relationship can facilitate the supervisor's ability to influence the supervisee, such that the supervisee is more likely to implement the supervisor's suggestions and thereby provide more effective therapy to the client (Patton & Kivlighan, 1997; Bernard & Goodyear, 1998).

Related to supervisee professional development, client welfare, and treatment outcome, another important function of supervision is to help supervisees manage their CT reactions to clients (e.g., Bernard & Goodyear, 1998; Williams et al., 1997). Supervision is one of the primary modalities for CT management, in addition to personal therapy and personal reflection (Hayes et al., 1998). In a study of novice therapists' experiences in prepracticum, Williams and colleagues (1997) found that trainees experienced a variety of reactions in sessions that interfered with their ability to provide effective counseling, and that these reactions were difficult to manage. Their supervisors observed three categories of reactions: 1) negative or incongruent behaviors, 2) avoiding client affect or issues, and 3) becoming overfocused, overinvolved, or losing objectivity. Such behaviors are likely indicative of CT reactions (e.g., Friedman & Gelso, 2000;

Gelso et al., 1995; Bandura et al., 1960). Over the course of the semester, the trainees became more adept at managing these reactions through several means, including processing the issues in supervision and increasing self-awareness in sessions. Other theorists have also highlighted the role of supervision in managing CT reactions toward sexual minority clients (e.g., Buhrke & Douce, 1991; Phillips & Fischer, 1998; Iasenza, 1989), racial minority clients (Gelso & Mohr, 2001), clients to whom the therapist is sexually attracted (Ladany et al., 1997), and sexually abused clients (Little & Hamby, 1996).

Despite the fact that supervision plays an important role in the management of supervisee CT, there are several possible reasons why CT management may not occur in supervision. One is that supervisees may not disclose their CT reactions in supervision; another is that supervisors may not detect supervisees' CT reactions, therefore being unable to initiate discussion in supervision. Research pertaining to why supervisees may not disclose CT reactions in supervision is reviewed first, followed by a review of the research on supervisor blind spots and CT reactions.

Reasons why countertransference management may not occur in supervision: The supervisee. One reason why supervisees may not disclose a CT reaction in supervision is the fact that the supervisory relationship is inherently power-imbalanced (Bernard & Goodyear, 1998; Slimp & Burian, 1994). It is power-imbalanced because of the responsibility of the supervisor to evaluate the supervisee and because of the greater experience and status of the supervisor. Supervisees often experience anxiety in the context of such a relationship. One technique used by supervisees to reduce their anxiety is impression management, also called strategic self-presentation (Bernard & Goodyear,

1998; Ward et al., 1985). Impression management refers to a supervisee's attempt to project a certain image (i.e., of competency). Supervisee impression management strategies might include selective disclosure or nondisclosure of information about self and clinical work, particularly if the supervisee believes the information poses a threat to their positive evaluation by the supervisor. For example, a supervisee might only discuss clients who are making good progress or areas in which he or she is performing well as a clinician (Ronnestad & Skovholt, 1993). In a study of supervisee nondisclosure, Ladany and colleagues (1996) found that some common issues that supervisees did not disclose to their supervisors were clinical mistakes, evaluation concerns, and negative reactions to the supervisor, and to a lesser extent, negative reactions to clients, countertransference, and attraction to a client. Common reasons cited for nondisclosure were deference to the supervisor, impression management, and fear of political suicide. These reasons reflect self-protective strategies on the part of the supervisee in the context of the power-imbalanced and evaluative supervisory relationship. However, the information withheld by supervisees may nevertheless be important to discuss in supervision (e.g., CT reactions to client), so it may be left to the supervisor to pick up on the issue and address it with the supervisee.

Another reason why supervisees may not disclose CT reactions in supervision is because of a poor supervisory working alliance. Bordin (1983) postulated that the key components of the supervisory relationship are mutual trust, liking, and caring between the supervisor and supervisee. In a relationship where such conditions are not met, supervisees may not feel safe enough to discuss issues that are sensitive, embarrassing, threatening, or reflect poorly on their work (Ladany et al., 1996). Long (1996) stresses

that supervisors must provide an environment where supervisees feel safe to explore their heterosexist biases or discomfort in working with LGB clients. In both the Ladany et al. (1996) study on supervisee nondisclosure and the Ladany et al. (1997) study of interns' experience of sexual attraction to a client, one of the reasons most frequently cited by supervisees for nondisclosure to supervisors was a poor working alliance with their supervisors.

A third reason why supervisees may not disclose their CT reactions to their supervisors has to do with the unconscious nature of CT (Freud, 1910/1959; Gelso & Carter, 1985, 1994; Gelso & Hayes, 2002). The previous reasons given for nondisclosure (i.e. fear of negative evaluation/power imbalance and poor supervisory alliance) have implied that the choice to disclose or not disclose sensitive issues to one's supervisor is consciously made (Bernard & Goodyear, 1998; Ladany et al., 1996; Ladany et al., 1997). But there may not, in fact, be any decision to make when it comes to disclosing CT reactions in supervision. Supervisees may simply not be aware that they are experiencing CT, particularly during their early stages of training when they are not familiar with the concept or do not know themselves as therapists well enough to recognize a reaction as countertransferential (Williams et al, 1997). It has been suggested that supervisors, as an observing third party with enough distance from the counseling relationship to be somewhat objective, may be in an optimal position to detect supervisee CT reactions (Bernard & Goodyear, 1998; Cutler, 1958; Kantrowitz, 2002; Williams et al, 1997; Long, 1996). However, no empirical research to date has been conducted on factors that determine supervisor ability to detect CT.

Reasons why countertransference management may not occur in supervision: The supervisor. Supervisor factors may also have an impact on the process of CT management in supervision. Supervisors can initiate discussion of unresolved or sensitive issues in supervision, thereby allowing the supervisee to work through these issues that may otherwise interfere with their work as therapists. In addition to strengthening the supervisory relationship by helping the supervisee work through difficult issues in a supportive context, the supervisor's approach, rather than avoidance, of sensitive material can provide good modeling for the supervisee as a therapist. The supervisee, having worked through sensitive unresolved issues in supervision, can feel empowered to help his or her clients do the same in therapy (Ladany et al., 1996; Ladany et al., 1997). In short, it seems important for supervisors to be able to pick up on and approach unresolved issues and conflicts faced by their supervisees.

However, supervisors may not pick up on and approach unresolved issues with their supervisees for a number of reasons. Supervisors, like supervisees, can have CT reactions tied to unresolved issues and conflicts (e.g., Ladany et al., 2000; Lower, 1972; Teitelbaum, 1990). Rather than initiating discussion of sensitive or conflictual topics, supervisors may collude with their supervisees to avoid these topics (Strean, 1991). Supervisors' management of CT in supervision may parallel supervisees' management of CT in therapy (e.g., Doehrman, 1976). Research in the area of supervisor CT has been almost entirely theoretical or anecdotal, and empirical work is very limited, compared to the research on therapist CT. The literature on supervisor CT will be reviewed next.

Supervisor CT may be defined as a complex process that involves unconscious and exaggerated reactions stemming from a supervisory interaction related to a

supervisor's unresolved personal issues or internal conflicts (Bernard & Goodyear, 1998; Lower, 1972). Another conceptualization of supervisor CT has been "supertransference," referring to the supervisor's blind spots, unresolved conflicts, or inappropriate expectations that may impact the supervisee's professional development and learning, self-esteem, or work with clients (Teitelbaum, 1990). Ladany et al. (2000) offered a somewhat broader definition of supervisor CT, including several components: a) a strong or exaggerated, unrealistic, irrational, or distorted reaction related to a supervisor's work with a trainee, b) including thoughts, feelings, and behaviors, in response to, c) a trainee's interpersonal style or personal issues, d) a trainee's behaviors, thoughts, or feelings toward a client, e) a trainee's client, f) interactions with a trainee, or g) a supervisor's own personality, personal issues, or past experiences.

Supervisor CT has been thought to have an influence on therapy process and outcome via "parallel processes," in which dynamics in the supervisor relationship are replicated in the supervisee's relationship with the client (e.g., Doehrman, 1976; Friedlander et al., 1989). Strean (1991) theorized that supervisor CT can contribute to impasses in the therapy relationship. Supervisors may have blind spots and unresolved conflicts that may lead them to collude with the supervisee to avoid dealing with these issues in the supervisory relationship. It is not until supervisor CT and supervisee transference to the supervisor are recognized and worked through that a similar working through can occur in the therapy relationship. Russell and Greenhouse (1997) proposed that a supervisor with unresolved issues around homosexuality may collude with a supervisee to resist discussion of sexual orientation issues in the supervisory relationship (particularly if the supervisee is a sexual minority). The supervisee may then collude with

sexual minority clients to resist discussion in a similar way. By not approaching sexual orientation issues, the supervisee may indirectly communicate to the sexual minority client discomfort with these issues or even homophobia. Doehrman (1976) provided empirical support for the existence of “parallel processes” between supervision and therapy, and found that treatment process and outcome was markedly improved when supervisees resolved conflicts in their relationships with their supervisors.

Only one empirical study to date has investigated supervisor CT (Ladany et al., 2000). In this qualitative study, supervisor CT was found to have similar manifestations to counselor CT (i.e., affective, cognitive, and behavioral components) as well as some similar sources (the supervisee’s interpersonal style, the supervisor’s unresolved issues) in addition to sources that are more specific to the nature of supervision (problematic supervisee-client interactions). Most supervisors reported managing their CT by talking with colleagues, and in most cases, successful management was associated with a strengthened supervisory relationship in the long-run. The findings of this study suggest that supervisors themselves must manage CT reactions if they are to be effective supervisors who can help supervisees deal with their own CT reactions.

To summarize, there are a variety of reasons why the important task of supervisee CT management may not occur in supervision. Supervisees may not disclose their CT reactions to their supervisors for fear of negative evaluation, especially in a supervisory relationship with a weak working alliance (Ward et al., 1985; Ladany et al., 1996; Ladany et al., 1997). Supervisees also may not disclose CT reactions because they may not be conscious of them (Gelso & Hayes, 2002; Williams et al., 1997). Finally, supervisors may resist discussion of supervisee CT reactions and the unresolved issues underlying the

reactions, because supervisors, too, have unresolved issues or blind spots (Ladany et al., 2000; Teitelbaum, 1990; Lower, 1972; Russell & Greenhouse, 1997). Although there is no research to date on what factors contribute to supervisor ability to detect supervisee CT, it might be that supervisors have difficulty detecting supervisee CT reactions that stem from similar unresolved issues. One area in which supervisors and supervisees may have similar unresolved issues or blind spots is in working with sexual minority clients, which is the subject of the next section.

Supervision and Counselor Training with LGB Clients

There are several reasons why supervisors, like supervisees, may have blind spots or unresolved issues with respect to LGB clients. One reason is that supervisors themselves may not be competent in working with LGB clients. Graham et al. (1984) noted the irony that the therapists in their study, who needed more training to work with lesbian and gay clients (due to negative attitudes, lack of knowledge, bad practices, or difficulty being objective), were nevertheless involved in training or supervising prospective therapists to work with the same clients. Other studies also reveal that many licensed psychologists, who may now be supervising graduate trainees in their work with LGB clients, had very little or no graduate training themselves with the LGB population (e.g., Murphy et al., 2002; Allison, Crawford, Echemendia, Robinson, & Knepp, 1994). Allison et al. (1994) surveyed clinical and counseling psychologists about graduate training experiences with LGB clients and found that the modal exposure to LGB clients during training was zero. A survey of clinical psychologists indicated that less than half received supervision on LGB issues during graduate training, while only 28% reported formal training on LGB issues (Murphy et al., 2002). The implications of supervisors'

lack of training specific to LGB issues may be that supervisors themselves have not had the opportunity to explore and challenge their own negative stereotypes and biases. In a study of heterosexist bias in training programs, graduate students reported incidents of supervisors making heterosexist comments or assumptions (Pilkington & Cantor, 1996). Gatmon (2001) reported that sexual orientation issues are rarely discussed in supervision, and that when discussions occur, they are usually initiated by supervisees.

Others have theorized the negative impact of supervisor heterosexism on supervisees' work with LGB clients. Heterosexist supervisors might be prejudiced toward supervisees' LGB clients, ignorant of their special contextual and developmental concerns, likely to pathologize or conceptualize them according to stereotypes, or insensitive (i.e., in their use of heterosexist language or in assuming clients are heterosexual) (Long, 1996; Phillips, 2000). Murphy et al. (2002) note that supervisors will tend to help supervisees conceptualize clients in ways that supervisors themselves understand. Therefore, if supervisors are biased or underinformed about LGB issues, they will have difficulty helping their supervisees make helpful conceptualizations of LGB clients. Heterosexist supervisors might also collude with supervisees to avoid discussion of sexual orientation issues, or might communicate discomfort or distaste regarding homosexuality or bisexuality (Russell & Greenhouse, 1997; Buhrke & Douce, 1991). Such supervision events can set up harmful parallel processes that are carried over to supervisees' therapy with LGB clients (Russell & Greenhouse, 1997; Buhrke & Douce, 1991; Doehrman, 1976).

If supervisors' unresolved issues can, in fact, detract from their ability to supervise effectively with LGB clients, then this is a matter for concern, because

supervision is an important component of training to work with LGB clients. Because of its close connection to clinical work, supervision affords unique opportunities to develop counseling competency with LGB clients (Phillips, 2000; Bernard & Goodyear, 1998). Supervisors can enhance their supervisees' competency by monitoring supervisees' work closely, challenging heterosexist biases, and taking necessary action when supervisees are found to be using insensitive approaches (e.g., making them aware of the impact of their interventions, increasing knowledge of LGB issues and ethical responsibilities, and practicing skills) (Long, 1996; Buhrke, 1989; Bernard & Goodyear, 1998; Constantine, 1997). Supervision can be important in helping supervisees manage the complex issues that may arise in working with LGB clients. For example, supervision may be helpful, especially to beginning trainees, in managing difficult client emotions such as anger over heterosexual privilege or rejection by one's family (Buhrke & Douce, 1991). Supervision can teach supervisees how to make important differential diagnoses in cases where LGB identity development processes may mimic symptoms of psychopathology (Dworkin, 2000; Buhrke & Douce, 1991). Iasenza (1989) noted that the exploration of homophobia and other unresolved issues in supervision is important for preventing CT distortions.

The importance of supervision in developing therapist competency with LGB clients is highlighted by several empirical findings. For example, counseling and clinical psychology graduates reported that their most helpful training experience with respect to providing services to diverse clients (including LGB) was supervision relevant to diverse cases (Allison et al., 1994). Phillips and Fischer (1998) found that graduate students who were encouraged to explore their heterosexist biases in supervision felt more prepared to work with LGB clients. Interestingly, students working with supervisors with expertise

on LGB issues actually experienced more discomfort initially in working with LGB clients because their supervisors had made them aware of the complexities of LGB issues and how much they had not previously understood (Phillips & Fischer, 1998). Also, supervisors' instruction to focus on multicultural issues was significantly related to supervisees' multicultural case conceptualization and treatment planning abilities (Ladany et al., 1997).

Clearly, supervision is an important component of overall LGB affirmative counselor training. However, evidence suggests that graduate training in general, and supervision specifically, may not be preparing trainees adequately to work with LGB populations. Several studies have reported that graduate students feel unprepared to work with LGB clients or concerned about the quality of training they have received specific to working with this population (e.g., Glenn & Russell, 1986; Buhrke, 1989; Buhrke & Douce, 1991; Phillips & Fischer, 1998). Trainees did not feel that their training encouraged them to challenge heterosexist biases (e.g., Buhrke & Douce, 1991; Phillips & Fischer, 1998). Trainees' actual amount of experience with LGB clients was limited (Murphy et al., 2002; Allison et al., 1994). Concerns over inadequate supervision were also reported in a number of studies. Female counseling psychology graduate students reported that supervision was less helpful for gay and lesbian clients than for heterosexual clients (Buhrke, 1989). A survey of clinical psychologists found that only half had received supervision on LGB issues. Of these, only half reported that their supervisors had been knowledgeable about LGB concerns (Murphy et al., 2002). Phillips and Fischer (1998) found that 75% of counseling and clinical psychology graduate students reported not having a supervisor with expertise in LGB issues. Finally, the

graduate students in the Buhrke and Douce (1991) investigation reported knowing more than their supervisors about LGB issues.

Compared to the attention given in the literature to improved training with sexual minority clients in general, the need for improved counselor training specific to bisexual issues has only been recently acknowledged (Phillips, 2000; Phillips & Fischer, 1998). Phillips and Fischer's (1998) investigation of graduate students found that counseling and clinical psychology graduate students were receiving less training in bisexual issues than in lesbian and gay issues. These trainees also felt less prepared to work with bisexuals. Murphy et al. (2002) likewise reported that 32% of practicing clinical psychologists felt they needed more training on working with bisexual clients. With bisexual clients, they often felt like they were guessing or extrapolating based on what they knew about lesbian and gay clients. These findings exemplify some concerns that have been expressed about the lack of inclusion of bisexual issues in counselor training, or the tendency to lump bisexual issues together with lesbian and gay issues while failing to acknowledge important differences (e.g., Betz, 1991; Phillips & Fischer, 1998; Phillips et al., 2003; Bieschke, McClanahan, et al., 2000; Fox, 1996).

The current study proposed one way in which training with bisexual clients may be lacking. The unresolved issues and negative attitudes of supervisors toward bisexuality may get in the way of their ability to supervise trainees' work with bisexual clients effectively. Specifically, supervisors' unresolved issues and negative attitudes may give rise to supervisor CT to a supervisee's bisexual client, which could make it more difficult for supervisors to detect and manage the supervisee's CT to the client. This study was also intended to offer implications for how LGB training could be improved. Specifically,

supervisors may need to examine and confront their negative attitudes toward bisexuals (e.g., Long, 1996; APA, 2000; Morrow, 2000). Supervisors may also need to take inventory of their knowledge base and increase their knowledge where lacking (APA, 2000). Lack of knowledge may especially be an issue in light of the fact that bisexual counseling issues are a recent development in the literature (Firestein, 1996; Phillips & Fischer, 1998). Continuing education and consultation may be helpful for this purpose (APA, 2000; Allison et al, 1994). Finally, supervisors must be alert to supervisee CT with sexual minority clients so that it can be detected and managed.

Chapter 3

Statement of the Problem

Although there has been a relative abundance of countertransference research in the past 25 years compared to its near absence before that time, the research has focused almost exclusively on countertransference (CT) in the counseling relationship (Gelso & Hayes, 2002). For example, research has examined therapist manifestations of CT, therapist ability to manage CT, and client and therapist predictors of CT, among other topics (e.g. Hayes et al., 1998; Hayes et al., 1991; Sharkin & Gelso, 1993; Gelso et al., 1995). Supervision has been implicated in the research indirectly in that supervisors have been utilized as raters of therapists' CT behavior and CT management ability (Friedman & Gelso, 2000; VanWagoner et al., 1991; Williams et al., 1997). It is surprising that supervision has not been addressed more directly in the CT literature, given the crucial role supervision plays in CT management. Supervision helps therapists process their CT reactions to clients, so that these reactions are not acted out in ways detrimental to the work of therapy (Bernard & Goodyear, 1998; Williams et al., 1997; Gelso et al., 2002; Hayes et al., 1997). Moreover, there are a variety of possible reasons why supervisees may not initiate discussion of CT in supervision, such that CT management through supervision may not occur. For example, supervisees may be unaware of their CT, hesitant to disclose personal reactions for fear of negative evaluation, or anxious about discussing threatening material because of a poor supervisory alliance (Gelso & Hayes, 2002; Bernard & Goodyear, 1998; Ward et al., 1985; Ladany et al., 1996; Ladany et al., 1997).

Despite the importance of CT management in supervision, and despite the

possibility that supervisees may not initiate discussion of CT reactions, no research to date has directly addressed supervisor ability to detect their supervisees' CT reactions. Thus, little is known about what qualities in a supervisor contribute to or detract from this ability. The present study addressed this issue. Specifically, it investigated: 1) whether *supervisor attitudes* (toward certain types of clients/presenting problems) relate to supervisor ability to detect *supervisee* CT behavior accurately, and 2) whether *supervisor CT reactions* to a supervisee's client (operationalized as distorted cognitive recall and increased state anxiety) relate to supervisor ability to detect *supervisee* CT accurately. In other words, *negative supervisor attitudes* toward a particular type of client might make it more difficult for the supervisor to detect a supervisee's CT to this type of client. Likewise, a *supervisor's CT reaction* to a supervisee's client could also make the supervisor less likely to notice the supervisee's CT to the client. In addition to looking at the relationships of supervisor attitudes (i.e., biphobia) and supervisor CT reactions (to the bisexual client) to supervisor CT detection accuracy (of supervisee CT toward a bisexual client), the present study also examined the relationship between supervisor attitudes and supervisor CT reactions, based on previous research that has demonstrated a link between therapist attitudes and therapist CT reactions (e.g., Gelso et al., 1995; Hayes & Gelso, 1993).

Supervision is an important component of counselor training, distinct from other components of training in its proximity and direct connection to clinical work (e.g., Bernard & Goodyear, 1998). As a result of this close connection, it is often a primary modality for developing trainees' multicultural competency, or ability to work with a diverse range of clients (Ladany et al., 1997; Constantine, 1997). Research suggests that

trainees may need training specifically focused on working with LGB clients (e.g., Buhrke & Douce, 1991; Phillips & Fischer, 1998). Trainees may have had only limited experience with LGB individuals prior to seeing LGB clients, and may therefore have only limited knowledge and understanding of the unique difficulties experienced by these individuals in a heterosexist society (Emert & Milburn, 1997; Phillips & Fischer, 1998; Morrow, 2000; Herek & Glunt, 1993). In addition, trainees themselves may have internalized societal prejudices and inaccurate stereotypes about sexual minority individuals (Glenn & Russell, 1986; Long, 1996; Emert & Milburn, 1997; Phillips, 2000). Such negative attitudes can lead to less effective clinical work and poorer outcomes for LGB clients through therapist CT reactions (Hayes & Gelso, 1993; Gelso et al., 1995; Gelso et al., 2002; Hayes et al., 1997). Supervision may help the trainee manage these CT reactions (Bernard & Goodyear, 1998; Long, 1996; Williams et al., 1997). As the supervisee may not initiate discussion of CT reactions for reasons previously mentioned, it may be left to the supervisor to detect the CT and initiate discussion.

In the case of supervision of clinical work with LGB clients, supervisors may have difficulty detecting supervisee CT because they may experience their own CT reactions due to negative attitudes and unresolved issues (blind spots) toward LGB individuals (Russell & Greenhouse, 1997; Ladany et al., 2000; Teitelbaum, 1990; Streaan, 1991; Lowe, 1972). While some studies have demonstrated a relationship between therapist homophobia and CT reactions toward lesbian and gay male clients, no studies to date have looked at the relationship between supervisor attitudes toward a population of clients and supervisor CT reactions to a supervisee's clients from that population (Gelso

et al., 1995; Hayes & Gelso, 1993). It seems like an important relationship to investigate, however, as it would presumably impact the supervisor's ability to detect the supervisee's CT reaction. A supervisor having a CT reaction similar to the supervisee's CT reaction might be "blind" to the supervisee's reaction. The implications of failing to detect supervisees' CT reaction may include possible failure to manage the CT in supervision and possible negative outcomes for the LGB client in the short-run (Gelso et al., 2002; Morrow, 2000). In the long-run, it may contribute to inadequate training and professional development of the supervisee in terms of competency with LGB clients (e.g., Phillips & Fischer, 1998).

Compared to the research on counseling lesbian and gay male individuals, there has been relatively little research on counseling bisexual individuals (Firestein, 1996; Fox, 1996; Phillips et al., 2003; Bieschke, McClanahan et al., 2000; Buhrke et al., 1992). This seems like an important area for further investigation, however, as bisexuals are also an oppressed group that may be seeking counseling to deal with the psychological consequences of this oppression (Firestein, 1996; Guidry, 1999; Matteson, 1996). Bisexuals share with lesbians and gays some issues, such as stigma over same-sex attraction and relationships, but they also have certain unique issues and concerns (Firestein, 1996; Fox, 1995; Guidry, 1999). Some issues unique to bisexuals may include stigma over their violation of the dichotomous, stable view of sexual orientation; lack of acceptance by either the heterosexual or gay communities; and lack of a bisexual community as a source of social support and identity (Firestein, 1996; Fox, 1995; Ochs, 1996; Robin & Hamner, 2000; Guidry, 1999). For these reasons, it is important for counselors working with bisexual clients to have competency specific to bisexual clients

(Phillips & Fischer, 1998). Supervision may be important for developing this competency (e.g., Phillips & Fischer, 1998; Long, 1996).

It seems likely that bisexual clients would elicit CT reactions in therapists, due to the prevalence of negative/conflictual attitudes, unresolved issues, and misunderstandings about bisexuality (e.g., Ochs, 1996; Mohr et al., 2001; Morrow, 2000). Though this has not been tested directly, one study found a relationship between biphobia and negative *anticipated* reactions toward a fictitious bisexual client after reading the client's intake (Mohr et al., 2001). The Mohr et al. (2001) biphobia study is the closest study in the literature to the Hayes and Gelso (1993) and Gelso et al. (1995) AV analogue studies on therapist homophobia as a predictor of CT (manifested cognitively, behaviorally, and affectively) toward gay male and lesbian clients, respectively. However, the Mohr et al. (2001) study looks at *anticipated* negative reactions rather than actual CT reactions to the bisexual client. The present investigation thus extended these three studies by looking at biphobia and CT reactions to a bisexual client via an AV analogue method (in this case, audio-analogue). Furthermore, it extended these three studies to the realm of supervision.

Based on the relationship identified by these three studies between *therapist* homophobia/biphobia and *therapist* (CT or negative anticipated) reactions to LGB clients, the present study predicted a similar relationship between *supervisor* biphobia and *supervisor* CT reactions to a supervisee's bisexual client. There are several reasons why a similar relationship was predicted. One reason is that the supervisor's CT reaction may stem from the same source as the therapist's/supervisee's, namely, unresolved issues and conflicts over bisexuality. Also, supervisors may experience supervisees' clients vicariously as their own, or put themselves in the supervisee's shoes (Ladany et al.,

2000). If the relationship between supervisor attitudes and supervisor CT reactions is similar to the relationship between therapist attitudes and CT reactions, then it follows that supervisor biphobia should predict supervisor CT toward a supervisee's bisexual client.

Hypothesis 1a: Supervisors' biphobia will be *positively* related to their CT reactions (manifested cognitively as distorted recall of session content and affectively as increased state anxiety while listening to the session) toward a supervisee's bisexual client.

Moreover, it seems unlikely that a supervisor could be very accurate at detecting a supervisee's CT reaction toward a client when the supervisor is having a similar CT reaction to the client. The supervisee's reaction might not stand out to the supervisor as somehow "off," as CT reactions often appear, because the supervisor is in the midst of the same reaction. The supervisor simply might not notice the supervisee's CT behaviors. Given the hypothesized relationship between supervisor biphobia and supervisor CT (toward a supervisee's bisexual client), supervisor biphobia might have a similar effect on a supervisor's ability to detect a supervisee's CT behavior toward a bisexual client (i.e., high biphobia might make a supervisor less accurate at detecting CT behavior toward a bisexual client). Hence, two relationships were hypothesized here: one between supervisor CT and supervisor accuracy of CT detection, and one between supervisor biphobia and supervisor accuracy of CT detection.

Hypothesis 1b: Supervisors' biphobia will be *negatively* related to their ability to detect a supervisee's CT behavior toward a bisexual client accurately (i.e., neither over- nor under-detecting supervisees' CT behavior).

Hypothesis 1c: Supervisors' CT reactions to a bisexual client, manifested cognitively

(distorted recall of session content) and affectively (increased state anxiety while listening to the session), will be *negatively* related to their ability to detect a supervisee's CT behavior to the bisexual client accurately (i.e., neither over- nor under detecting supervisees' CT behavior).

There may also be a relationship between supervisor biphobia and the type of CT behavior, positive or negative, that can be detected most accurately. Positive CT behavior, as identified by Friedman and Gelso (2000), is therapist behavior that seems supportive, but in a merging, enmeshed, or dependent way. Though it has a positive valence, it is still indicative of therapist personal conflicts. Negative CT behavior is therapist behavior that is punitive, avoidant, or aggressive in some way (Friedman & Gelso, 2000). Previously, it was suggested that supervisors may have difficulty detecting a supervisee's CT reaction when the supervisors are having similar CT reactions to the client. Extending this line of thought, we thought that supervisors would have greater difficulty detecting the *type* of supervisee CT behavior, positive or negative, that is most similar to the supervisor's reactions. For example, supervisee negative CT behavior might be harder to detect when a supervisor is having a negative CT reaction to the supervisee's client. Similarly, supervisee positive CT behavior would be harder to detect when a supervisor is having a positive CT reaction. In other words, supervisors may be *less* inclined to notice, or less accurate at detecting, supervisee reactions that are *consistent* with their own. Conversely, they may be *more* inclined to notice, or more accurate at detecting, supervisee reactions that are *inconsistent* with their own.

Here, supervisors may be more accurate at detecting the type of therapist CT behavior (positive or negative) toward a bisexual client that is more *inconsistent* with

their attitude toward bisexuals. For example, supervisors *high* in biphobia may be better at detecting *positive* (rather than negative) CT behavior in their supervisees because positive CT seems *too* supportive and may stand out as unusual to a supervisor who would have difficulty being supportive with a bisexual client. The biphobic supervisor's personal reaction may be closer to negative CT, making it more difficult to detect a similar negative reaction in a supervisee. In other words, when it comes to detecting negative CT behavior, the supervisor high in biphobia may have a blind spot. Conversely, supervisors *low* in biphobia may be better at detecting *negative* (rather than positive) CT behavior because they may be more tuned in or even hypervigilant about detecting negative or prejudicial reactions to bisexuals. However, since these supervisors themselves would likely be very supportive when working with bisexual clients, they may have a blind spot when it comes to detecting supervisee CT behaviors that are *too* positive or supportive. Thus, the following hypotheses proposed differential accuracy of detection of *negative versus positive* CT behavior toward a bisexual client as a function of supervisors' level of biphobia.

Hypothesis 2a: Supervisors *high in biphobia* will detect supervisee *positive* CT behavior toward a bisexual client *more accurately* than negative CT behavior.

Hypothesis 2b: Supervisors *low in biphobia* will detect supervisee *negative* CT behavior toward a bisexual client *more accurately* than positive CT behavior.

Finally, regardless of level of biphobia, it seemed plausible that supervisors would be more accurate at detecting negative CT behavior toward a bisexual client than positive CT behavior. One reason may be that negative CT behavior (e.g., rejecting client, becoming distant and apathetic, criticizing client, etc.) may look more obviously like bad

therapy than positive CT behavior (e.g., being overly supportive) because therapy is supposed to be supportive. Another reason may be that negative CT behavior toward a bisexual client would seem “politically incorrect,” even to supervisors high in biphobia. Even though these supervisors have negative attitudes toward bisexuals, they may be aware that they are “supposed” to have and exhibit positive attitudes (Rudolph, 1988). Since either type of CT behavior can have a detrimental effect on therapy, accurate detection is important in both cases (Friedman & Gelso, 2000).

Hypothesis 3: On the whole, supervisee *negative* CT behavior toward a bisexual client will be detected *more accurately* (i.e., lower rates of over- and under-detection) than positive CT reactions.

Chapter 4

Method

Research Design

This study used a correlational audio-analogue design to investigate the relationships among supervisor *attitudes* toward bisexuality (i.e., biphobia), supervisor *countertransference (CT) reactions* to a supervisee's bisexual client (measured affectively and cognitively), and supervisor *accuracy of detection of a supervisee's CT* toward a bisexual client. Additionally, this study examined differences in supervisors' accuracy of detection of *positive versus negative* CT behavior toward a bisexual client, both overall and as a function of supervisor biphobia level. Bivariate correlations and *t*-tests were employed as the basic analytic approaches. Though causal relationships could not be inferred from this correlational design, this study aimed to highlight predictive relationships that could be tested experimentally in future research.

Participants

A sample of 47 licensed mental health professionals and trainees with sufficient clinical experience to supervise were used as participants in this study. This sample size was consistent with other analogue CT studies (e.g., Gelso et al., 1995; Hayes & Gelso, 1993; Latts & Gelso, 1995), as well as realistic, given practical constraints in identifying eligible participants. The inclusion criteria used for participants in the present investigation were more selective than the criteria used in previous analogue CT studies that have focused on therapist, rather than supervisor, variables. For the present study, only trainees with sufficient clinical experience to supervise beginning counselors, and preferably trainees who had actual supervision experience, were used. Sufficient clinical experience was defined as at least 60 client hours or 3 practica. These criteria guided

recruitment of participants; however, the criteria were not absolute due to differences in curriculum and training structure across graduate programs from which participants were recruited. Graduate trainees were recruited primarily from counseling and clinical psychology doctoral programs at a large mid-Atlantic university, as well as university counseling centers at the same university and other local universities with predoctoral interns. Graduates of mental health professional programs pursuing both academic and clinical careers were also recruited from the large mid-Atlantic university. These participants included core faculty of doctoral programs in counseling psychology and clinical psychology; adjunct or affiliate faculty of the counseling psychology doctoral program (many of whom were employed locally as private practitioners or university counseling center staff); faculty of masters' and doctoral programs in college student personnel programs; and staff members of the university counseling center.

Our sample consisted of 32 women and 15 men, with ages ranging from 22-60 (mean age was 37), and some diversity in terms of race and sexual orientation. While the majority of the sample ($n = 32$) was European American, the sample also included African-American ($n = 8$), Asian/Pacific Islander ($n = 3$), Hispanic/Latino ($n = 2$), Middle Eastern ($n = 1$), and biracial ($n = 1$) participants. Likewise, while the majority of participants identified as heterosexual ($n = 41$), the sample also included bisexual ($n = 3$) and lesbian ($n = 3$) participants. (Although there was also an option for "gay" in the sexual orientation demographic item, none of the participants selected this option.) Slightly more than half of the sample (55.3%) consisted of graduate students/therapists-in-training ($n = 26$), while the remainder of the sample consisted of postgraduate mental health professionals ($n = 21$), the majority of whom were practicing clinicians either full-

time or part-time (e.g., in academic positions, but still performing some clinical roles such as practicum supervision, part-time private practice, or research evaluating the efficacy of clinical interventions).

Of the graduate student sample, 17 participants were currently enrolled in counseling psychology doctoral programs, 9 were currently enrolled in clinical psychology doctoral programs, and 6 were currently on predoctoral internship. Of the postgraduate mental health professional sample, 9 were currently employed as counseling center staff, 4 were currently involved in full-time private practice, 7 were employed in academic positions, and 1 was employed part time at a community mental health facility. Participants' highest degrees included both Ph.D. ($n = 20$) and masters' ($n = 21$) in counseling psychology or related fields (e.g., clinical psychology, counselor education, and college student personnel). Regarding theoretical orientation, participants were asked to rank their identification with up to three theoretical orientations. Participants' top ranked theoretical orientations included psychodynamic ($n = 17$) and humanistic/existential/client-centered ($n = 17$), followed by CBT ($n = 8$), multicultural/feminist ($n = 5$), and behavioral ($n = 4$).

As can be seen in Table 1, the graduate student sample was extremely diverse in terms of amount of clinical experience. Graduate students had completed between 1 and 7 practica ($M = 4.88$, $SD = 1.45$) in a wide range of settings and on varying topics, e.g., individual counseling, group counseling, counseling supervision. The majority of graduate students in the sample had done at least 1 externship ($n = 17$), with number of externships ranging from 0-3, at a variety of sites. The postgraduate mental health professional sample was also very diverse in terms of overall clinical experience. Both

Table 1

Summary of Clinical Experience of Participants (N = 47)

	Graduate Students					Postgraduate Mental Health Professionals				
	Mean	Median	Mode	SD	Range	Mean	Median	Mode	SD	Range
Overall Amt. Clinical Experience	615 ^a	500 ^a	500 ^a	451 ^a	100-2000 ^a	16 ^b	13.5 ^b	25 ^b	10.2 ^b	.25-33 ^b
Total # Hrs: Gay Male Clients	23.6	4.5	0	60	0-300	178	100	100	226	0-1000
Total # Hrs: Lesbian Clients	16.4	4	0	34.5	0-150	191	100	100	252	0-1000
Total # Hrs: Bisexual Clients	7.4	2.5	0	9.7	0-30	51.7	30	50	60.5	0-200
Total # Gay Male Clients	2.5	1	0	5.1	0-25	71	10	5	226	0-997
Total # Lesbian Clients	2.3	1	0	4.5	0-20	75.5	10	5	227	0-997
Total # Bisexual Clients	1	.5	0	1.5	0-5	8	5	1	11.6	0-50
Total # Hrs Supervision Experience	17.7	11	0	19.5	0-50	497	500	500	481	0-2000
Total # Supervisees	3.4	2	0	4.2	0-13	66	37.5	100	70	0-300
Total # Hrs/Wk currently spent on supervision	.84	0	0	2.1	0-10	2.8	3	0	2.3	0-8

Note. ^aunits are # hours. ^bunits are # years (of postgraduate clinical experience).

groups tended to have more experience with lesbian and gay male clients than with bisexual clients. While for both groups it was common to not currently be supervising anyone, the postgraduate sample had substantially more supervision experience and more variability in supervision experience than the graduate student sample.

Stimulus Tapes

Unlike other CT analogue studies that have used video analogues (e.g. Hayes & Gelso, 1993; Gelso et al., 1995), the present study used an audio analogue. This method was selected to enhance the study's external validity by making the supervision experience as realistic as possible for participants. Listening to a cassette tape of a supervisee's session was thought to be the most commonly used method of supervision. Thus, using an audio analogue method should make the results of the study more readily generalizable to actual supervision.

Script. The content of the audio-tape included a heterosexual male counseling trainee (the participant's fictitious supervisee) conducting a session with a bisexual male client, in which the trainee exhibited CT behaviors as defined by the Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). A written transcript of the session can be found in Appendix B. The choice of heterosexual male counselor and male bisexual client, as opposed to any other gender combination, was made to increase the effect size. It was thought that CT behavior, though possible in any gender combination, would be the highest and the most salient in a heterosexual male counselor-male sexual minority client dyad. Research has found that men are higher overall in homophobia than women, and that gay men elicit greater homophobia overall than lesbian women (Herek, 1988; Kite & Whitley, 1996; Eliason, 2001). Thus, a male counselor (particularly a

heterosexual male) might be expected to be higher in homophobia (and presumably biphobia) than a female counselor, and more likely to experience CT toward a sexual minority client. Also, a male sexual minority client would be expected to elicit a greater CT reaction in his counselor than a female sexual minority client. A male sexual minority client was also expected to elicit more CT in supervisor participants in the study, creating a larger and more measurable effect than might have been observed if a female sexual minority client had been used as the stimulus. Finally, a same-gender dyad seemed appropriate in light of Gelso et al.'s (1995) finding that female counselors had greater CT than male counselors toward an analogue lesbian client.

The content of the session was based on the Mohr et al. (2001) study, in which counselors read an intake of a fictitious female bisexual client seeking counseling at a university counseling center. In that intake, the client's presenting problems were identified as career indecision, negotiating emotional boundaries/separation-individuation with parents, and romantic relationships (she had broken up from a long-term relationship with a woman and was now in a relationship with a man who felt uncomfortable about her bisexuality). The intake also specified that none of her presenting problems were related to personal dissatisfaction with her bisexuality. The present study featured an analogue counseling session with a male bisexual client with presenting problems similar to those of the female client in the Mohr et al. (2001) study. Similarly, his issues include distress over issues of career indecision (trying to decide if he should apply to medical school), separation-individuation from family (feeling pressured by his family to go to medical school), and romantic and sexual relationships (feeling sad and conflicted over his recent break-up from a relationship with a woman; current casual sexual involvement

with a close male friend). Though identifying himself as bisexual, he does not express distress over his sexual orientation or relate it to his presenting problems.

There are several reasons why the session content in the present study was based on the Mohr et al. (2001) study. First, in the Mohr et al. (2001) study, counselor biphobia predicted negative *anticipated* reactions to the bisexual client with the presenting problems described above; therefore, we might expect that counselor biphobia would predict CT reactions when actually working with such a client. Supervisee CT behavior toward a bisexual client with these presenting problems should thus be realistic.

A second reason these presenting problems were used is that they are typical developmental concerns for many college students. The presenting problems stem from issues around identity, intimacy, and autonomy, which are theorized as major developmental conflicts for college students according to some college student development models such as Chickering and Reisser's (1993) psychosocial theory. Thus, in this respect, the session would also be realistic for a supervisee working with a counseling center client. Additionally, the fact that these concerns are normal and developmental means they are not necessarily related to a client's sexual orientation, although they may be. One negative stereotype of bisexual individuals is that they suffer from identity diffusion in general, such that they cannot "make up their minds" or settle on one sexual orientation. Thus, a college student who is experiencing career indecision and is also bisexual may be seen as having a diffuse identity in general. While some individuals do, in fact, identify as bisexual as they are exploring their sexual identity and may later identify otherwise (e.g., heterosexual or gay/lesbian), other individuals identify as bisexual in a stable and long-term way (e.g., Diamond, 2000, 2003; Robin & Hamner,

2000; Guidry, 1999; Fox, 1995). In sum, the issues presented by the fictitious client in this analogue are developmentally normal for a college student, yet have the potential to be pathologized by a counselor in light of the client's bisexuality. A counselor having a CT reaction to such a client might pathologize the client by viewing his bisexuality as part of a larger problem of identity diffusion, or might relate his presenting problems (i.e., career indecision) to his bisexuality unnecessarily. To ensure that such a reaction is indeed a CT reaction rather than an accurate conceptualization of the client, the analogue client was made to be a relatively well-adjusted college student who does not express dissatisfaction with his bisexuality. It is the counselor, rather than the client, who makes an issue out of the client's bisexuality.

A final reason why the audio-analogue session in the present study was based on the Mohr et al. (2001) study is that the latter study included romantic and sexual issues among the presenting problems of the fictitious client. It was thought to be particularly useful to the present study for the analogue bisexual client to discuss, among other topics, romantic and sexual issues (i.e., his former romantic and sexual relationship with a woman, and current sexual relationship with a male friend). In addition to being a normal concern for college students, the topic of sex and relationships seems like it would have great potential to elicit a CT reaction, particularly in a heterosexual male counselor working with a bisexual male client. Such a topic might also have potential to be pathologized or related to the client's bisexuality unnecessarily, due to stereotypes about bisexuals being sexually promiscuous (e.g., Firestein, 1996). Additionally, romantic and sexual issues might be more likely than other topics to elicit CT reactions in the supervisor participants (e.g., Gelso et al., 1995). As discussed later, recall of sexual words

used by the client was used as a cognitive measure of supervisors' CT.

The script was also written to include CT behaviors on the part of the supervisee. It was intended for these behaviors to be subtle, rather than overt or obvious, thus requiring detection on the part of the participants. Although the supervisee initially responds empathically and appropriately to the client's career concerns and distress over breaking up with his girlfriend, it is when the client mentions his sexual involvement with a male friend that the supervisee begins to exhibit CT behaviors. The supervisee directs the focus of the session to the meaning of the client's sexual involvement with a man, and how it might mean that the client is coming out as gay, even though the client seems well-adjusted and stable in his bisexuality. Despite the client's attempts to return the focus of the session to his presenting concerns, the supervisee remains stuck on the fact that the client is bisexual, presumably because of his own conflicts or unresolved issues. In sum, the supervisee "misses" the client by focusing on his bisexuality unnecessarily, rather than meeting him empathically and responding to his presenting concerns.

In order to ensure that the script was realistic, it was rated on believability on a 5-point Likert scale (1 = very unbelievable, 5 = very believable) by four independent judges (see Appendix C). These judges were advanced doctoral students in counseling psychology (i.e., post-masters' level). They were selected on the basis of their relatively extensive clinical experience, because it was thought that they would be competent to judge whether the script sounded realistic as a counseling session (both in general and specifically as a session conducted by a practicum student at a university counseling center with an undergraduate client). Three of the four judges were members of the author's advisee group, and thus were aware of the study's hypotheses. The script was

found to have a mean of 4.75 ($SD = .5$) for believability. The script met the minimum requirement of a mean score of 3 (out of 5) on the believability scale, suggesting it was sufficiently believable to be used in the present study.

Actor training and ratings. Actors were recruited via announcements/flyers in the theater department, flyers in the psychology building, and posting to university LGBT listservs. Seven actors were auditioned using the script, and five actors were invited back to record the tapes. Three of the five actors had prior acting experience. Our intent was to make several versions of the tape using different combinations of the actors, pick the best two versions, and have these two versions rated by judges. The tapes were made over the course of two sessions (a four hour session and a three hour session), one with three actors present and one with the remaining two actors present. In both sessions, actors received training on how to act out the counselor and client roles. Actors were instructed that, while sticking to the content of the speaking turns as much as possible, they should read the lines as they would personally speak them. For example, they could add in phrases they would use in everyday speech such as “you know,” “like,” “um,” “man,” etc., or change the wording of a line to sound more natural. It was hoped that the sessions would sound more realistic if actors were given the freedom to speak the lines in a natural way, rather than sounding like actors reading from a script. Actors were given more specific instructions or modeling in some cases, for example, an emotion to emphasize, times to pause, or the way a therapist might sound delivering a particular intervention. They were given the opportunity to practice their roles (in most cases, the actors played both roles in different combinations with the other actors) and given feedback on their delivery by the author and her research assistant, until it was determined that they were

prepared to record the tapes.

Six preliminary versions of the tape were recorded over the course of the two acting sessions. Among the versions of the session that were generated, the researcher and her advisor selected what they believed to be the best two versions, taking into consideration quality of acting and potentially confounding idiosyncracies in actors' speech or delivery. It was originally intended that both of these versions would be used in the study in order to test for actor/session effects, but whether each tape could be used in the study depended on the ratings it received from judges.

Five independent judges listened to both versions of the tape and rated the counselor and client actors from each version on 5-point Likert scales (1 = very low, 5 = very high) on the dimensions of likeability, attractiveness, and believability of delivery, in addition to rating the session on the amount and subtlety of CT behavior (see Appendix D). These five judges all had Ph.D.'s in counseling psychology and were selected because of their expertise in CT. All five judges had at least one publication on a CT topic, and three had either published extensively on CT or had been the author of widely cited CT or therapy relationship studies. Four of the five judges were currently providing psychotherapy, conceivably giving them the opportunity to think about CT on a regular basis.

Regarding ratings of counselor and client actors, only one version of the tape received acceptable ratings, meeting the minimum requirements of a mean Likert score of 3.00 on the dimensions of likeability, attractiveness, and believability; neither of the actors on this tape had prior acting experience (see Table 2).

Table 2

Means and Standard Deviations of Actor Performance Ratings By Judges (N = 5)

Actor	Therapist	Client
Likeability	3.3 (.97)	4.2 (.45)
Attractiveness	3.3 (.67)	3.8 (.84)
Believability	3.9 (.74)	4.2 (.84)

Note. Standard deviations are listed in parentheses.

By contrast, the second version of the tape was not found to be acceptable for use in the study because the counselor ratings on this version did not meet the minimum requirements of a mean of 3.0 on the likeability, attractiveness, and believability dimensions. Although the client in this version received adequate ratings ($M = 3.8$, $SD = .84$ for likeability; $M = 3.8$, $SD = 1.1$ for attractiveness; $M = 3.4$, $SD = .89$ for believability), the counselor ratings were too low ($M = 2.6$, $SD = .55$ for likeability; $M = 2.6$, $SD = .89$ for attractiveness; $M = 2.4$, $SD = .55$ for believability). In addition to the low ratings, spontaneous comments from several judges about negative reactions to the counselor actor's speech and delivery style suggested that using this tape might introduce systematic error that could make results difficult to detect. Therefore, we decided to use only the version of the tape that received acceptable ratings from the judges, notwithstanding the methodological limitation introduced by using only one version of the tape rather than two versions (which allows for testing of actor/session effects). It was our judgment that the limitation posed by using a problematic version of the tape was more potentially serious than the limitation posed by not being able to test for actor/session effects. Previous analogue studies on CT have used two versions of analogues to test for actor effects but have not found any actor effects (e.g., Hayes & Gelso, 1993; Gelso et al., 1995; Harbin, 2004); therefore, we reasoned that using one version of an analogue in this study would not be likely to threaten the validity of the present study, assuming that the version of the tape we used received acceptable ratings.

Countertransference behavior ratings. In addition to rating the likeability, attractiveness, and believability of actors, the five judges with expertise in CT also rated the audiotaped sessions (taken together, not by version) on the amount and subtlety of CT

behavior. Judges rated the session independently on the Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000), with ICB ratings calculated as a sum of the items on the total scale and subscales. The mean of the judges' ratings was defined as the "actual" amount of CT behavior in the session, or the absolute score on the ICB.

Absolute CT scores were obtained for overall CT, positive CT, and negative CT.

Supervisor participants' ratings of CT behavior on the ICB were subtracted from these absolute scores to yield deviation scores, indicating how much they over- or under-detected the supervisee's CT behavior (overall, positive, and negative) in the session.

The session was intended to have a moderate degree of counselor CT behavior according to the judges' ratings on the ICB measure, although attempts were made to make the behavior subtle (thus requiring detection ability on the part of the supervisors), rather than clearcut or obvious. Scores on the ICB measure tend to be low in general (e.g. Ligiero & Gelso, 2002; Friedman & Gelso, 2000), so it was expected that a moderate amount of CT behavior in the session would be reflected by somewhat low ICB scores as rated by the judges, compared to the total possible score on the measure. Although deviation scores for supervisor CT detection were calculated using ICB item totals (i.e., sums of items), mean item scores for ICB ratings are reported here. Mean item scores on a 5-point scale (where 1 = "to no extent" and 5 = "to a great extent") were 1.74 ($SD = .46$) for total CT behavior, 1.47 ($SD = .45$) for positive CT behavior, and 2.0 ($SD = .52$) for negative CT behavior. These relatively low scores suggest that the session indeed contained moderate amounts of total, positive, and negative CT behavior.

The judges also rated the session on the obviousness of the CT behavior on a 5-point Likert scale (1 = not obvious at all, 5 = very obvious). The mean of the judges'

obviousness ratings was 2.5 ($SD = .866$). Thus, the session met the minimum requirement on the obviousness dimension (less than mean of 3.0 on Likert scale), suggesting that the CT behavior in the session was sufficiently subtle to be appropriate for the present study. See Table 3 for a summary of CT behavior ratings.

Measures

Demographics. Participants completed a demographic measure (see Appendix J) assessing their age, gender, race/ethnicity, sexual orientation, theoretical orientation (could rank up to 3), type of degree earned or currently being pursued (e.g., Ph.D. or Master's, what field), years or approximate hours of experience doing therapy, types of clinical experiences for graduate students (practica and externships), extent of experience as a supervisor (hours, number of supervisees, number of hours/week currently spent doing supervision), and extent of experience with LGB clients (hours and number of clients).

Attitudes Regarding Bisexuality Scale (ARBS-FM; Mohr & Rochlen, 1999; see Appendix F). It was hypothesized that supervisor attitudes toward bisexuality (i.e., biphobia) would be correlated with both supervisor CT reactions to a supervisee's bisexual client and supervisor accuracy of detection of a supervisee's CT toward a bisexual client. Supervisors' attitudes toward bisexuality were also hypothesized to relate to the type of supervisee CT behavior (positive or negative) that could be detected most accurately. To measure supervisors' attitudes toward bisexuality, this study used the Attitudes Regarding Bisexuality Scale (ARBS; Mohr & Rochlen, 1999). The ARBS has three versions: the ARBS-FM to assess general attitudes about bisexuality (18 items--9 items involving a bisexual female target and 9 items involving a bisexual male target),

Table 3

Mean Item Scores and Standard Deviations of Ratings of Session Countertransference Behavior By Judges (N = 5)

<u>Dimension</u>	<u>M</u>	<u>SD</u>
Amt. of total CT Behavior--ICB	1.74	.46
Amt. of positive CT Behavior--ICB	1.47	.45
Amt. of negative CT Behavior--ICB	2.0	.52
Obviousness of CT Behavior	2.5	.87

the ARBS-F to assess attitudes about female bisexuality (12 items), and the ARBS-M to assess attitudes about male bisexuality (12 items). All three versions contain 2 subscales: Tolerance and Stability. Tolerance assesses the degree to which bisexuality is viewed as a tolerable, moral sexual orientation that is not harmful to society and reflects acceptance, rather than disdain, for bisexual people. Stability assesses the extent to which bisexuality is viewed as a legitimate, stable sexual orientation, and the extent to which bisexuals are seen as capable of forming committed romantic relationships and friendships. Because we were interested in general attitudes toward bisexuality, the present study used the ARBS-FM scale.

Each item on the ARBS-FM scale is rated on a 5-point Likert scale (1 = strongly disagree, 5 = strongly agree). Example items from the Stability and Tolerance subscales include: “Most men who claim to be bisexual are in denial about their true sexual orientation” (Stability) and “As far as I’m concerned, female bisexuality is unnatural” (Tolerance). Although the original scale designates higher scores as indicating more positive attitudes toward bisexuals, or lower biphobia (example items were reverse scored), scores were reversed for data analysis in the present study such that higher scores reflect greater biphobia.

Both subscales had high internal consistency reliability in previous studies, with alpha estimates of .94 for Tolerance and .89 for Stability (Mohr et al., 2001). Test-retest reliability estimates were also high for both subscales, with estimates of .91 for Tolerance and .85 for Stability over a 3-week time period (Mohr & Rochlen, 1999). In the present sample, alpha estimates were .88 for the entire scale, .61 for the Tolerance subscale, and .90 for the Stability subscale. The low alpha for the Tolerance subscale means that

participants did not answer these items in a consistent way, suggesting that the items did not hang together well as a subscale in this sample. Although the Tolerance subscale was still used in some statistical analyses (e.g., correlations), the low alpha suggests interpreting analyses involving the Tolerance subscale with caution.

The ARBS-FM measure was developed using samples of both lesbians/gay men as well as heterosexuals. In a sample of heterosexual women and men, subscales were most strongly related to attitudes toward lesbians and gay men; frequency of religious attendance; political ideology; and prior contact with lesbian, gay, and bisexual people. In a sample of lesbians and gay men, subscales correlated with prior experiences with bisexual people, desired contact with bisexual people, contact with heterosexual people, and view of one's sexual identity as mostly (though not exclusively) lesbian/gay. Validity estimates were higher for the Tolerance subscale in the heterosexual sample, while they were higher for the Stability subscale in the lesbian/gay sample.

Assessment of supervisor CT. We hypothesized that supervisor CT toward a supervisee's bisexual client would be related to both supervisor biphobia and supervisor ability to detect the supervisee's CT toward the client. Supervisor CT was assessed via cognitive and affective measures used in other CT analogue studies (e.g. Gelso et al., 1995). Cognitive recall measures assess the ability to recall provocative material expressed by client, generally in comparison to the frequency with which the client actually verbalized the material. For example, in the Gelso et al. (1995) study on CT toward a lesbian client, the cognitive recall measure was the difference between counselors' recall of the number of sexual words used by the client and the actual number of sexual words used by the client. Distortion in either direction (recall of too many or

too few words) indicates a CT reaction, based on research showing that therapists over-recall or under-recall conflictual material (Cutler, 1958). In general, the utility of the cognitive recall measure is that it is not subject to social desirability and thus possibly a “truer” measure of CT. The present study followed the protocol of the Gelso et al. (1995) study and assessed supervisor recall of sexual words and phrases used in the session. Affective measures of CT have generally assessed state anxiety (e.g., Gelso et al., 1995; Sharkin & Gelso, 1993), under the premise that CT reactions are associated with increased anxiety. Cognitive and affective CT were examined separately as predictors of supervisor ability to detect CT. Overall supervisor CT (a composite of cognitive and affective CT) was also examined in additional analyses.

Cognitive CT assessment. Supervisor cognitive countertransference was hypothesized to be correlated with both supervisor biphobia and supervisor CT detection accuracy. Gelso et al. (1995) found that female counselors had greater cognitive recall problems than male counselors with a lesbian client, whereas male and female counselors had equally good recall with a heterosexual female client. This finding provides evidence for the construct validity of the cognitive recall measure.

To assess cognitive CT, supervisors were asked to remember the number of sexual words or phrases used in the audiotaped session (see Appendix H). Cognitive recall scores were calculated as absolute deviations from the actual number of sexual words and phrases used in the session (as rated by judge consensus), in order to determine the accuracy of supervisors’ recall of provocative material. Judge consensus on the actual number of sexual words and phrases on the tape was established by a team of 5 judges, three of whom were advanced doctoral/post-masters’ level students in

counseling psychology who had previously judged the script on its believability, in addition to the researcher (a third-year doctoral student in counseling psychology) and her advisor (a professor of counseling psychology with expertise in CT research and 34 years of postgraduate clinical experience). The judges met to read a transcript of the session, one speaking turn at a time, and discussed the number of sexual words/phrases in each speaking turn until consensus was reached (see Appendix C, consensus meeting). It was agreed that neither pronouns (e.g., “it”) nor references to sexual orientation (e.g., “bisexual” or “gay”) would be counted as sexual words/phrases. The total number of sexual words/phrases in the session determined by the judge consensus was 26.

Affective CT assessment. Supervisor affective CT was also hypothesized to be correlated with both supervisor biphobia and supervisor CT detection accuracy. Affective CT was assessed by measuring supervisor state anxiety. This study employed a state anxiety measure commonly used in CT studies (e.g. Hayes & Gelso, 1991, 1993; Gelso et al, 1995; Sharkin & Gelso, 1993; Harbin, 2004), the State portion of the State-Trait Anxiety Inventory (STAI-S; Spielberger et al., 1970; see Appendix G). It consists of 20 items rated on a Likert scale from 1 = “not at all” to 4 = “very much so.” This measure has been found to have high internal consistency reliability. For example, Hayes and Gelso (1993) estimated its internal consistency to be between .83 and .96. Also, the measure has low test-retest reliability, as would be predicted given that state anxiety is situational. Test-retest reliability was estimated between .16 and .33 for 1 hour, .27 - .54 over 20 days, and .31 - .33 over 104 days (Dreger, 1978). In the present sample, internal consistency reliability was .85. The validity of the STAI-S (Spielberger et al., 1970) has been demonstrated through research in which hypotheses regarding state anxiety were

supported (e.g., Hayes & Gelso, 1991; Sharkin & Gelso, 1993). Overall, the STAI-S has been established as a sensitive indicator for the transitory anxiety experienced in counseling (Spielberger, 1976).

Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000; see Appendix D). The ICB assesses supervisor-perceived CT behavior in counseling sessions. It was used in the present study to measure supervisor detection of supervisee CT behavior (toward a bisexual client) in the audio-analogue session. This 21-item measure contains two subscales, Positive CT and Negative CT. Positive CT behavior is therapist behavior that appears supportive, but in a merging, enmeshed, or dependent manner. Negative CT behavior is therapist behavior that is punitive, avoidant, or aggressive. There are 10 items on the Positive CT subscale and 11 items on the Negative CT subscale. Each item on the ICB is rated on a 5-point Likert scale, with responses ranging from 1 (“to little or no extent”) to 5 (“to a great extent”). An example item is: “The therapist rejected the client in the session.” Three scores are obtained for each participant: a total score, a Positive CT behavior score, and a Negative CT behavior score. Total scores can range from 21 to 105 with subscale scores ranging from 10-50 for Positive CT and 11-55 for Negative CT. Higher scores on the ICB indicate more CT behavior observed in the session.

In the present sample, internal consistency reliability estimates were .84 for the entire scale, .73 for the positive CT subscale, and .84 for the negative CT subscale, similar to alphas in previous studies (Friedman & Gelso, 2000; Ligiero & Gelso, 2002). Convergent validity evidence also supports the usefulness of this measure. The ICB total scale, as well as each of the subscales, has significant positive correlations with the

Countertransference (CT) Index (Hayes et al., 1997), an existing 1-item measure of CT behavior (Friedman & Gelso, 2000; Ligiero & Gelso, 2002). Additionally, Friedman and Gelso (2000) found significant negative correlations between the ICB, a measure of acted-out CT behavior, and the Countertransference Factors Inventory-Revised (CFI-R; Latts, 1996), a measure of therapists' ability to manage their CT. Finally, Ligiero and Gelso (2002) found that the negative CT subscale of the ICB was negatively related to the quality of the therapist-client working alliance as rated by both supervisors and therapists. Also, the positive CT subscale was negatively related to the bond component of the working alliance as rated by supervisors. These findings further support the validity of the measure, given that acted-out CT behavior would be theoretically predicted to have a negative impact on the therapeutic working alliance.

Procedure

Participant recruitment. Methods of recruiting participants included electronic mail, phone calls, and face-to-face requests to participate. Participants were told that they would be participating in an analogue study on supervision, in which they would fill out a packet of measures, listen to an audiotape, and then fill out another packet of measures, for a total time commitment of approximately 40-50 minutes. They were not informed of the study's hypotheses in advance. To ensure confidentiality, participants were assigned codes that were used instead of their names.

Data collection. The majority of participants ($n = 41$) met with a research assistant (a female senior psychology major) or the author in person, either at the participant's office or the author's lab, to participate in the study. Participants first completed an informed consent form, which told them they would be listening to an

audio-analogue therapy session from the perspective of a supervisor and rating their perceptions of and reactions to the session. Next, participants were asked to fill out a packet of measures that contained a measure of biphobic attitudes (ARBS-FM; Mohr & Rochlen, 1999). To prevent participants from guessing the study's hypotheses, the biphobia measure was nested in a series of conceptually related measures (i.e., multicultural, homophobia, and gender role measures) that were not used as actual data. Participants then received instructions about the tape they would be hearing (see Appendix A). The instructions stated that this study was about supervision of novice therapists working with clients who differ from them with respect to sexual orientation. This was a cover story to prevent participants from guessing the study's hypotheses. Participants were told to assume that the therapist on tape was their supervisee (working with clients at a university counseling center), that they had an ongoing or semester-long supervisory relationship with this supervisee, and that this supervisee has mastered at least the basic helpingskills of doing therapy (i.e., had already completed the beginning practicum). They were also told that this supervisee was a heterosexual male. A brief description of the client's background (bisexual male, in his junior year at the university) and presenting problems (family, career indecision, and relationships) was given. Participants were told that they would be evaluating the therapists' behaviors and interactions with the client, as well as reporting their own reactions to the session.

Participants then listened to the 20-minute audiotape of the session, in which their male supervisee exhibited CT behaviors toward his male bisexual client (see Appendix B for transcribed session). After listening to the tape, participants completed affective and cognitive measures of their own CT reactions, followed by the Inventory of

Countertransference Behaviors (Friedman & Gelso, 2000) to assess their detection of supervisee CT behaviors. Participants then filled out a demographic measure. Finally, participants were debriefed (see Appendix K), thanked for their participation in the study, and instructed not to speak to others about the study.

Six participants did not participate in the study in person, but rather were mailed or delivered a packet of study materials with detailed instructions about the procedure they were to follow (see Appendix E).

Chapter 5

Results

The present study tested three sets of hypotheses. The first set of hypotheses proposed bivariate correlations among supervisor biphobia, supervisor countertransference (manifested affectively and cognitively), and supervisor accuracy of detection of supervisee countertransference (CT) toward a bisexual client. Specifically, we predicted a) a positive correlation between supervisor biphobia and supervisor CT; b) a negative correlation between supervisor biphobia and supervisor CT detection accuracy; and c) a negative correlation between supervisor CT and supervisor CT detection accuracy. The second set of hypotheses proposed differential ability to detect *negative versus positive* CT accurately as a function of supervisors' level of biphobia. Specifically, it was predicted that a) supervisors high in biphobia would detect positive CT toward a bisexual client more accurately than negative CT, and b) supervisors low in biphobia would detect negative CT toward a bisexual client more accurately than positive CT. Finally, a third hypothesis proposed that the supervisee's negative CT toward a bisexual client would be detected more accurately by supervisors than positive CT. An alpha level of .05 was used for all statistical analyses.

To address the first set of hypotheses, bivariate correlation coefficients were computed. The hypothesis predicting a positive correlation between supervisor biphobia and supervisor CT (both affective and cognitive) was not supported by the data, $r = -.10$, $p > .05$ for affective CT and $r = .06$, $p > .05$ for cognitive CT. The hypothesis predicting a negative correlation between supervisor biphobia and supervisor CT detection accuracy was not supported for detection of *total* CT, $r = -.14$, $p > .05$. However, there was a

significant correlation between supervisor biphobia and detection of *negative* CT, although in the opposite direction of the hypothesis. Specifically, a positive correlation was found between supervisor biphobia and supervisor accuracy of detection of negative CT, $r = .34, p < .05$. This relationship was largely accounted for by the Stability component of supervisor biphobia, as evidenced by the significant positive correlation between biphobia-Stability and accuracy of detection of negative CT ($r = .41, p < .01$); the correlation between biphobia-Tolerance and accuracy of negative CT detection was nonsignificant ($r = .07, p > .05$). Taken together, these findings suggest that the less likely supervisors were to believe that bisexuality is always a stable sexual orientation, the more accurate they were at detecting a supervisee's negative CT toward a bisexual client. Finally, the hypothesis predicting a negative correlation between supervisor CT (both affective and cognitive) and supervisor CT detection accuracy was not supported. Neither affective nor cognitive CT was correlated with accuracy of CT detection (total, negative, or positive). Refer to Table 4 for a correlation matrix.

The second set of hypotheses predicted differences between high and low biphobia supervisors in ability to detect positive and negative CT. However, the sample as a whole was very low in biphobia (see Table 5 and Additional Analyses), such that the “high” biphobia supervisors in the present sample were actually low-moderate in biphobia; the “low” biphobia supervisors were extremely low, as low as possible, in biphobia. Therefore, it was thought to be misleading to call the low-moderate group of supervisors the “high biphobia” group as stated in Hypotheses 2a and 2b. Hence, in the analyses addressing the second set of hypotheses as well as subsequent analyses, the biphobia groups will be referred to as “very low” and “low-moderate,” rather than “low”

Table 4

Pearson Correlation Coefficients for Variables in Hypotheses

Variables	1	2	3	4	5	6	7	8
1. Biphobia Total	1	.96*	.76*	.06	-.1	-.14	.26	-.34*
2. Biphobia--Stability		1	.55*	.08	-.21	-.15	.28	-.40*
3. Biphobia--Tolerance			1	-.02	.2	-.06	.11	-.07
4. Supervisor CT (Cognitive)				1	-.27	-.13	-.10	-.07
5. Supervisor CT (Affective)					1	.02	-.13	.18
6. CT Detection Accuracy—Total						1	.69*	.78*
7. CT Detection Accuracy—Positive							1	.17
8. CT Detection Accuracy—Negative								1

Note. $N = 47$; * $p = .05$, two-tailed.

and “high” as originally conceptualized under the assumption of greater variability in biphobia in the sample. To address the second set of hypotheses, the sample was divided into “very low” biphobia and “low-moderate” biphobia groups using a median split at 29. Paired samples *t*-tests were performed within each biphobia group to test for differences in accuracy of positive versus negative CT detection. The low (here, “very low”) biphobia group, hypothesized to be able to detect negative CT toward a bisexual client more accurately than positive CT, actually demonstrated just the opposite pattern; they detected positive CT significantly more accurately than negative CT, $t(22) = 5.18, p < .001$. The hypothesis predicting that the high (here, “low-moderate”) biphobia group would detect positive CT toward a bisexual client more accurately than negative CT was not supported, $t(20) = .474, p > .05$. Thus, the “low-moderate” biphobia group did not differ in their accuracy of detection of positive versus negative CT.

To address the third hypothesis, a paired samples *t*-test was performed on the entire sample to test for overall differences between the accuracy of negative versus positive CT detection. The hypothesis predicting greater accuracy of detection of negative CT toward a bisexual client was not supported, $t(46) = 1.789, p > .05$. An examination of the means for positive and negative CT detection accuracy suggests that that positive CT was detected more accurately than negative CT, although the difference was not significant ($M = 5.7$ for positive CT; $M = 7.3$ for negative CT; larger number indicates less accuracy as these are absolute deviation scores).

Additional Analyses

Measures of central tendency and variance. Table 5 presents mean item scores, mean scale scores, medians, standard deviations, actual ranges, and possible ranges for

Table 5

Measures of Central Tendency and Variance for Variables in Hypotheses

Variable	Mean Item Score	Mean Scale Score	Median Scale Score	Range	Possible Range
Biphobia Total ^a	1.6 (.46) ^b	29.1 (8.4)	29	19-49	18-90
Biphobia-Stability ^a	1.9 (1.1) ^b	19.3 (6.5)	18	11-34	10-50
Biphobia-Tolerance ^a	1.2 (.35) ^b	9.8 (2.8)	8	8-21	8-40
Supervisor CT (Affective)	1.5 (.36) ^c	30.4 (7.1)	29	20-46	20-80
Supervisor CT (Cognitive) ^d	N/A	17.1 (19.3)	14	1-124	N/A
CT Detection Accuracy—Total ^d	N/A	12.2 (7.9)	10.4	.4-33.4	N/A
CT Detection Accuracy—Positive ^d	N/A	5.7 (4.7)	5.3	.3-18.3	N/A
CT Detection Accuracy—Negative ^d	N/A	7.3 (4.8)	6.1	.1-20.1	N/A

Note. $N = 47$; SD 's in parentheses.

^a Higher scores indicate higher biphobia. ^b On a 5-point scale. ^c On a 4-point scale. ^d Indicates absolute deviation scores.

supervisor biphobia (including both Stability and Tolerance subscales), supervisor affective CT, supervisor cognitive CT, and supervisor CT detection accuracy for total, positive, and negative CT. An examination of the table reveals that the sample as a whole was relatively low in biphobia (mean item score = 1.6 on a 5-point scale where higher scores indicate higher biphobia; $SD = .46$). Indeed, the higher biphobia group in the present sample was not actually high in biphobia, but rather in the low-middle range on the biphobia scale (mean item score = 2.04; $SD = .33$), while the lower biphobia group was at the extreme low end of the scale (mean item score = 1.22, $SD = .13$). Supervisors scored slightly higher on the Stability subscale than on the biphobia scale as a whole, and with greater variability (mean item score = 1.9, $SD = 1.1$), while they scored relatively low and with little variability on the Tolerance subscale (mean item score = 1.2, $SD = .35$). Thus, supervisors tended to disagree about the extent to which bisexuality is a stable sexual orientation, while they were in agreement that it was a morally acceptable sexual orientation.

Exploratory Analyses. For all exploratory analyses, an adjusted alpha of .01 was used. This more stringent level of alpha was chosen for exploratory analyses in order to reduce the likelihood of Type I errors.

Given the exploratory nature of the present study (i.e., it is the first study of its type), it was thought to be important to examine relationships among all of the variables in the study (not just the variables in the hypotheses), as such relationships may provide fruitful directions for future research. Therefore, a correlation matrix (Appendix L) was generated to include additional variables not tested in the hypotheses (i.e. amounts of total, negative, and positive CT behavior observed in the session by participants; the

number of sexual words recalled; and supervisor composite CT, a variable generated by summing supervisor affective and cognitive CT scores that is an overall representation of supervisors' CT reactions), along with the variables from the hypotheses. As can be seen in Appendix L, a number of correlations were significant at the .01 level. There were also several relationships that approached significance (i.e., they were significant at the .05 level but not at the more stringent .01 level used for exploratory analyses); although these relationships should be regarded with caution, they are highlighted here because of the exploratory nature of the study. Given that this line of research is relatively new, it was thought that the risk of Type II error (i.e., failing to detect a relationship that might stimulate new directions for future research) could be potentially more serious than the risk of Type I error.

The amount of supervisee *negative* CT behavior toward the bisexual client reported by supervisors was negatively correlated with supervisor cognitive CT ($r = -.41$, $p = .001$) and with the number of sexual words recalled ($r = .41$, $p = .001$). Additionally, a negative correlation between the amount of *total* CT behavior reported by supervisors and supervisor cognitive CT approached significance ($r = -.35$, $p < .05$, $> .01$); although not significant at the .01 level, this correlation paralleled the significant correlation between the supervisor-reported amount of *negative* CT and supervisor cognitive CT. Taken together, these correlations suggest that the more CT behavior (particularly negative CT) toward the bisexual client supervisors perceived in the session, the less distorted was their recall of the session; specifically, they were less likely to over-recall sexual words.

Although not significant at the .01 level, several correlations between the amount

of negative CT reported and other variables approached significance (i.e., $.01 < p < .05$). Specifically, the amount of negative CT behavior reported by supervisors was positively correlated with supervisor affective CT (i.e., anxiety) ($r = .29, p < .05$) and negatively correlated with biphobia-Stability ($r = -.30, p < .05$). Another relationship approaching significance was the negative correlation between supervisor affective CT (anxiety) and the number of sexual words recalled from the session ($r = -.29, p < .05$). Taken together, these results may suggest an emerging pattern, in which supervisors very low in biphobia (specifically, those who believe very strongly that bisexuality is a stable sexual orientation) tend to perceive more negative CT toward the bisexual client; supervisors who perceive more negative CT toward the bisexual client tend to feel more anxious; and supervisors who feel more anxious tend to recall fewer sexual words. While much caution should be exercised in interpreting these relationships, it is possible that their lack of significance was due to a small sample size.

Given that the amount of CT behavior reported by supervisors (especially negative CT behavior) was correlated with a number of other variables, additional investigation of supervisors' perceptions of the amount of CT behavior was performed. Overall, supervisors perceived more negative supervisee CT in the session than positive CT, $t(46) = 6.61, p < .001$. They were accurate in this respect in that there was more negative CT in the session according to the expert judges' ratings ($M = 21.9$ for negative CT; $M = 14.7$ for positive CT). In other words, supervisors rightly perceived more negative CT behavior than positive CT behavior toward the bisexual client in the session.

Although supervisors were accurate in their perception of the relative amounts of negative and positive CT behavior in the session, it appeared that they were inaccurate in

estimating the actual amount of CT behavior toward the bisexual client as rated by the expert judges. Specifically, supervisors appeared to have a tendency to over-detect CT behavior in the session (i.e., to observe more CT behavior toward the bisexual client than was actually there). To test whether supervisors over-detected CT behavior toward the bisexual client more frequently than they under-detected it (i.e., missed or failed to detect the CT behavior), one-way chi-square tests were performed in which participants' detection of total, positive, and negative CT behavior were dichotomized into being either higher or lower than the actual amount of total, positive, and negative CT behavior in the session (i.e., the expert judges' ratings). All three of the chi-square tests were found to be significant ($\chi^2(1, N = 46) = 20.45, p < .001$ for total CT; $\chi^2(1, N = 46) = 20.45, p < .001$ for positive CT; $\chi^2(1, N = 47) = 11.26, p < .001$ for negative CT). An examination of the frequencies revealed that for all three types of CT behavior (i.e., total, positive, and negative), participants indeed over-detected CT behavior more frequently than they under-detected it in the session ($n = 38$ compared to $n = 8$ for total CT; $n = 38$ compared to $n = 8$ for positive CT; $n = 35$ compared to $n = 12$ for negative CT). In other words, supervisors tended to perceive *more* supervisee CT behavior toward the bisexual client than was actually there, more often than they missed or failed to detect the CT behavior toward the bisexual client.

While supervisors tended to over-detect CT behavior in the session, they neither systematically under-recalled nor over-recalled the number of sexual words/phrases used in the session. A one-way chi-square test, in which recall of the number of sexual words/phrases was dichotomized into being either higher or lower than the actual number of sexual words/phrases, was not significant, $\chi^2(1, N = 47) = 1.043, p > .05$. Although

distorted recall in either direction is thought to be countertransferential, participants did not distort in either direction more frequently than the other direction.

Other exploratory analyses revealed differences between the “low-moderate” biphobia and “very low” biphobia groups in accuracy of CT detection toward a bisexual client. An independent samples *t*-test found that the “very low” biphobia supervisors on the Stability subscale (identified via a median split at 19) detected *positive* CT toward a bisexual client significantly more accurately than the “low-moderate” biphobia (Stability) group ($t(44) = -2.63, p < .01$). Independent samples *t*-tests comparing the “very low” biphobia and “low-moderate” biphobia groups on detection of *negative* CT did not reveal significant differences; however, a comparison of the accuracy of detection of negative CT by the two groups suggested that the “low moderate” biphobia group over detected negative CT less than the “very low” biphobia group. One -sample *t*-tests comparing the amount of negative CT observed by each biphobia group to the absolute amount of negative CT in the session (as judged by expert raters) found greater differences in the “very low” biphobia group ($t(22) = 3.973, p < .01$) than the “low-moderate” biphobia group ($t(20) = 2.251, p > .01$). In sum, results suggest that “*very low*” biphobia supervisors (specifically those who believe strongly in the stability of bisexuality) are more accurate at detecting *positive* CT toward a bisexual client than “low-moderate” biphobia supervisors (i.e., those who believe bisexuality is not always stable.) While it cannot be concluded definitively that “low-moderate” biphobia supervisors are more accurate than “very low” biphobia supervisors at detecting *negative* CT toward a bisexual client, results tentatively suggest that the “*low-moderate*” biphobia supervisors did not over-detect negative CT toward the client as much as the “very low” biphobia

supervisors.

Finally, we wondered whether the data supported our theory that supervisor CT and supervisor biphobia, taken together, predict supervisor ability to detect supervisee CT toward a bisexual client. Therefore, a simultaneous multiple regression was performed using cognitive CT, affective CT, and biphobia (total) as predictors, and accuracy of CT detection (total) as the criterion. This overall model was not significant, $F(3,46) = .516, p > .05$. It was noted that the Stability component of biphobia and the negative CT component of CT (detection accuracy and amount observed) were the biggest contributors to variance on their respective scales, and that differences and relationships with other variables were found more often with these subscales than with the parent scales. Therefore, a second simultaneous multiple regression was performed using cognitive CT, affective CT, and biphobia (Stability) as predictors, and accuracy of negative CT detection as the criterion. This overall model, although not significant at the .01 level used for exploratory analyses, approached significance, $F(3,46) = 3.009, p < .05, r\text{-square} = .173$. Additionally, biphobia (Stability) contributed significantly as a predictor of negative CT detection ability, with a beta weight of .385, $p = .01$. Thus, it was largely the biphobia component of the model that predicted supervisor accuracy of detection of negative CT. Similar to the result described earlier in the test of Hypothesis 1b, supervisors who were less likely to believe that bisexuality is always a stable sexual orientation were more accurate at detecting supervisee negative CT behavior toward a bisexual client.

Chapter 6

Discussion

The present study was a correlational laboratory analogue designed to examine the relationships among supervisor biphobia, supervisor countertransference reactions (to a supervisee's bisexual client), and supervisor accuracy of detection of a supervisee's countertransference (CT) to a bisexual client. This section will include a discussion of findings relevant to the study's hypotheses as well as results of exploratory analyses. Additionally, limitations of the present study, implications for counseling/supervision, and directions for future research will be presented.

Findings Relevant to Hypotheses

Supervisor biphobia and supervisor CT. The first hypothesis predicted a positive correlation between supervisor biphobia and supervisor CT (toward a bisexual client). We expected that *supervisor* biphobia would predict *supervisor* CT toward the bisexual client in the same way that *therapist* homophobia and biphobia predicted *therapist* CT reactions or negative anticipated reactions toward gay, lesbian, and bisexual clients, respectively (Hayes & Gelso, 1993; Gelso et al., 1995; Mohr et al., 2001). Supervisors' CT reactions were expected to follow the same pattern as therapists' for two reasons: first, because the reactions would stem from a common source, namely unresolved issues and conflicts over bisexuality; and second, because supervisors may experience supervisees' clients vicariously as their own (Ladany et al., 2000). This hypothesis was not supported by the data; no relationship was found between supervisor biphobia and supervisor CT at either the affective or cognitive levels.

One possible explanation for the lack of relationship is that our conceptualization

of supervisor CT as a reaction *to the bisexual client* may have been mistaken. Supervisors may instead have been having CT *to the session* or to the supervisee's behavior. For example, supervisor affective CT (anxiety) was assessed immediately after supervisors listened to the session, via a state-anxiety inventory that asked supervisors to report how anxious they felt while listening to the session. This assessment is problematic in that we have no way of determining the source of supervisors' anxiety on the basis of their responses. It is possible that, as we theorized, supervisors' anxiety was related to discomfort over the client's bisexuality (i.e., they had an affective CT reaction toward the bisexual client). However, it is also possible that supervisors felt anxious as they listened to a session in which their supervisee conducted incompetent or unhelpful therapy with a bisexual client. Their CT reactions may not have been to the bisexual client, but to the *supervisee's behavior* (i.e., his use of inappropriate or insensitive interventions). The finding that supervisors who observed more negative CT in the session felt more anxious ($r = .291, .01 < p < .05$) supports this alternative interpretation. Such an interpretation is likewise supported by other research which found that problematic supervisee-client interactions were a common source of supervisor CT (Ladany et al., 2000). In actual supervision settings, this alternative interpretation seems especially plausible as supervisors may be aware of their basic ethical responsibility to ensure that supervisees' clients receive adequate care, as well as their vicarious responsibility for client welfare (e.g., Vasquez, 1992; Harrar et al., 1990; Bernard & Goodyear, 1998).

Another alternative explanation for the lack of relationship found between supervisor biphobia and supervisor CT is that supervisor CT was assessed only at the affective and cognitive levels. In contrast to previous analogue CT studies (e.g., Hayes &

Gelso, 1993; Gelso et al., 1995), supervisor CT in the current study was not assessed at the behavioral level, as supervisors were not given the opportunity to approach or avoid conflictual client material. However, the relationships found in these previous studies between therapist homophobia and CT toward a sexual minority client held only at the behavioral level (i.e., therapist homophobia predicted a tendency to use avoidant responses with the sexual minority client) (Hayes & Gelso, 1993; Gelso et al., 1995). Thus, in future analogue studies investigating supervisor CT toward sexual minority clients, it may be helpful to use behavioral measures of supervisor CT.

A third possible reason for the lack of relationship between supervisor biphobia and supervisor CT is that there was not enough variability in biphobia in our sample (i.e., restricted range) to detect the relationship. Supervisors in the current sample were very low overall in biphobia, similar to the low homophobia samples used in the Hayes and Gelso (1993) and Gelso et al. (1995) gay male and lesbian CT studies. Future studies might attempt to recruit a more diverse sample of supervisors in terms of attitudes about bisexuality.

Supervisor biphobia and supervisor CT detection accuracy. The next hypothesis predicted a negative relationship between supervisor biphobia and supervisor accuracy of CT detection toward a bisexual client. It was reasoned that the higher supervisors were in biphobia, the less accurate they would be at detecting the supervisee's CT behavior toward the bisexual client, as the CT behavior would not stand out to them as inappropriate. A significant relationship was found between supervisor biphobia and accuracy of detection of supervisee *negative* CT, although in the opposite direction of the hypothesis. In other words, the higher supervisors were in biphobia, the *more* accurate

they were at detecting the supervisee's negative CT toward the bisexual. This relationship was largely accounted for by the Stability component of biphobia; specifically, supervisors who were less likely to believe that bisexuality is *always* a stable sexual orientation were more accurate at detecting the supervisee's negative CT toward the bisexual client.

To understand this finding, it is important to note that supervisors "high" in biphobia in the present sample were still in the low-middle range on the biphobia scale. These supervisors tended to score slightly higher on the measure not because of intolerance of bisexuality, but because of the belief that bisexuality is a stable sexual identity for *some* individuals, while for others it is a transitional identity (e.g., to identification as gay or lesbian). The belief that bisexuality is *sometimes* a transitional identity is supported by research suggesting that some individuals identify as bisexual prior to or following identification as exclusively gay or lesbian (e.g., Diamond 2000, 2003; Fox, 1995; Murphy et al., 2002). Thus, supervisors who believed that bisexuality is not *always* a stable sexual orientation (the "low-moderate" biphobia supervisors) may actually have been more accurate in this respect than the "very low" biphobia supervisors, who more likely endorsed beliefs suggesting that bisexuality is *always* a stable sexual orientation. It is possible that the "low-moderate" biphobia supervisors in the present sample, able to acknowledge that bisexuality is not *always* a stable sexual orientation, were being more honest, less defensive or politically correct, or were basing their responses on actual clinical experiences with bisexual clients. Indeed, several participants with large amounts of clinical experience spontaneously commented that they had trouble deciding whether they agreed or disagreed with certain items on the

biphobia measure because they could think of examples of some bisexual clients for whom the statement was true and other bisexual clients for whom it was *not* true (e.g., “Bisexual women have a clear sense of their true sexual orientation”).

It is also possible that the “very low” biphobia supervisors in this sample, who scored as low as possible on the biphobia measure, were responding to items in a socially desirable or politically correct way. In all likelihood, they were able to ascertain from the biphobia measure, which has considerable transparency as well as face validity (see Appendix F), that it was a measure of attitudes about bisexuality; and they may have been biased toward responding as positively/affirmatively as possible.

Thus, a possible explanation for the finding that higher supervisor biphobia predicted greater accuracy of detection of negative CT toward a bisexual client is that the “low-moderate” biphobia supervisors in the current sample may have had a more complex and accurate understanding of client sexual orientation issues (based on clinical experience in some cases) than the low-biphobia supervisors. Additionally, the “low-moderate” biphobia supervisors may have been more honest or less defensive/politically correct than the “very low” biphobia supervisors in reporting their attitudes about bisexuality, perhaps suggesting greater insight/self-awareness into their biases around bisexuality. With this self-awareness, the “low-moderate” biphobia supervisors may have been better able to manage their own CT, which could perhaps explain why they were more accurate at detecting the supervisee’s (negative) CT behavior. The validity of these explanations should be tested in future research.

Supervisor CT reactions and supervisor CT detection accuracy. This hypothesis predicted a negative relationship between supervisor CT reactions (toward the bisexual

client) and supervisor accuracy of CT detection toward the bisexual client (in other words, the more CT supervisors experience, the less accurate they would be at detecting the supervisee's CT). The rationale for this hypothesis was similar to the rationale given for the previous hypothesis, namely that when supervisors have a blind spot or unresolved conflict (experienced as a CT reaction) similar to that of a supervisee (who presumably acted out his internal conflict as CT behavior), supervisors will miss the supervisee's CT because they are in the midst of a similar reaction. The data did not support this hypothesis, as this correlation was non-significant. Thus, it does not appear that supervisor CT reactions (toward a bisexual client) predict supervisors' ability to detect a supervisee's CT behavior toward the bisexual client accurately. Perhaps supervisors were able to manage their CT reactions such that these reactions did not impede their CT detection ability.

Alternative explanations should also be considered. One possible explanation for the non-significant finding might be, as discussed earlier, that supervisors' CT was not directed to bisexual client as theorized, but to the session or to the supervisee's inappropriate behavior/interventions. Additionally, given the low levels of biphobia in the sample, it would not seem that supervisors had the same blind spot or unresolved conflict with bisexuality as the hypothetical supervisee.

High ("low-moderate") biphobia group versus low ("very low") biphobia group: Accuracy of detection of positive versus negative CT behavior. This hypothesis was two-fold. First, it was predicted that supervisors low in biphobia would be able to detect negative CT more accurately than positive CT; conversely, it was predicted that supervisors high in biphobia would be able to detect positive CT more accurately than

negative CT. These hypotheses were based on our reasoning that supervisors would be more accurate at detecting the type of therapist CT (positive or negative) toward a bisexual client that is more *inconsistent* with their attitude toward bisexuals. For example, supervisors *high* in biphobia would be better at detecting positive (rather than negative) CT in their supervisees because positive CT would seem *too* supportive and would stand out as unusual to a supervisor who would theoretically have difficulty being supportive with a bisexual client. On the other hand, supervisors *low* in biphobia would be better at detecting negative CT than positive CT because they would be more tuned in or even hypervigilant about detecting negative or prejudicial reactions to bisexuals. Given the low overall biphobia in the sample (and lack of variability), we were unable to test for differences between high and low biphobia supervisors and instead tested for the hypothesized differences between “low-moderate” and “very low” biphobia supervisors.

The first part of this hypothesis, regarding supervisors low (here “very low”) in biphobia, was found to be in the opposite direction of our prediction. Specifically, it was found that “very low” biphobia supervisors were more accurate at detecting *positive* CT than negative CT. Additional analyses revealed that “very low” biphobia(Stability) supervisors (supervisors who believed strongly that bisexuality was a stable sexual orientation) were more accurate than the “low-moderate” biphobia(Stability) supervisors (i.e., those who believed that bisexuality was sometimes a stable sexual orientation) at detecting positive CT. One possible explanation for “very low” biphobia supervisors’ ability to detect positive CT toward a bisexual client relatively accurately is that they were aware of their bias toward being *too* positive or supportive with bisexual clients, and were thus on the lookout for similar supervisee behaviors (in other words, they were

better at detecting the type of CT that was more *consistent* with their attitudes toward bisexuals, rather than inconsistent).

An explanation that appears more plausible involves the nature of the positive CT behaviors in this session. The supervisee uses several psychoeducational interventions informing the client about the coming-out process, in an attempt to normalize and validate what he thinks is the client's development of a gay identity (despite the client's apparent stability and satisfaction in his bisexual identity). Additionally, the supervisee approaches, rather than avoids, the client's discussion of his sexual relationship with a man, but to an inappropriate extent (as this relationship is not an area of concern or distress to the client) and in a way that tries to frame the relationship as part of the client's process of coming out as gay (when the client identifies as bisexual). Such interventions are indicative of positive CT because, while seemingly supportive, they are inappropriate and appear to stem from the supervisee's needs, rather than the client's (Friedman & Gelso, 2000). It would make sense that these interventions, in particular, may have stood out to the "very low" biphobia supervisors (i.e., those who believed strongly in the stability of bisexuality) as countertransferential because they seem to question the client's bisexual identity inappropriately. The "low-moderate" biphobia supervisors (i.e., those who didn't believe that bisexuality is always a stable sexual orientation) may not have thought these interventions were as obviously inappropriate as the "very low" biphobia supervisors did, because they tended to believe that bisexual clients are indeed sometimes in the process of coming out as gay. By not recognizing these interventions as countertransferential, the "low-moderate" biphobia supervisors were less accurate at detecting positive CT.

The second part of this hypothesis, predicting that the high (here, “low-moderate”) biphobia supervisors would be better at detecting positive CT than negative CT, did not receive support. In other words, “low-moderate” biphobia supervisors were equally accurate at detecting both positive and negative CT, although they tended to over-detect both types of CT (as did the low-biphobia supervisors). Perhaps the “low-moderate” biphobia supervisors’ equally accurate detection of both types of CT is related to our previous speculation that these supervisors had a more accurate understanding of the complexities of bisexuality, as well as more awareness and less defensiveness about their biases around bisexuality. Such qualities in the “low-moderate” biphobia supervisors may have made them equally adept at detecting positive and negative CT behavior, or at least no more biased toward detecting one type (CT that is inappropriately supportive) versus the other (CT that is critical or rejecting). In other words, the “low-moderate” biphobia supervisors may have been more balanced in their attention to supervisee positive and negative CT behaviors toward the bisexual client.

Although the “low-moderate” biphobia group did not detect negative CT toward the bisexual client more accurately than the “very low” biphobia group, exploratory analyses found that the “low-moderate” biphobia group over-detected negative CT toward the bisexual client to a *lesser* extent than the “very low” biphobia group. One possible explanation for the “very low” biphobia group’s greater tendency to over-detect negative CT toward the bisexual client, compared to the “low-moderate” biphobia group, is that their extremely positive attitudes toward bisexuality made them very tuned in or even hypervigilant about detecting the supervisee’s negative CT behaviors toward the client (i.e., behaviors that were critical, rejecting, etc.). Such hypervigilance could have

led “very low” biphobia supervisors to observe far more negative CT than was actually there. This proposed explanation warrants further investigation in future research.

Overall accuracy of detection of positive versus negative CT behavior. The final hypothesis predicted that overall, negative supervisee CT behavior toward the bisexual client would be detected more accurately than positive supervisee CT behavior. It was thought that negative CT toward the bisexual client would stand out more obviously as bad therapy (e.g., the therapist rejecting or criticizing the client) than positive CT, which could arguably be more subtle (e.g., the therapist being *too* supportive, but therapy is supposed to be supportive). The data did not support this hypothesis. Actually, positive supervisee CT behavior was detected more accurately than negative CT behavior, although not significantly so. Overall, it can be concluded that supervisors are able to detect positive and negative supervisee CT behavior toward a bisexual client with equal accuracy (although in the current sample, they over-detected both types).

It is unclear how to interpret this null finding in light of the fact that the session contained different amounts of positive and negative CT (specifically, it contained more negative CT). Future research might investigate whether the relative amount of positive and negative CT behavior in the session has any impact on supervisors’ relative accuracy of detection of each type (e.g., perhaps the type of CT behavior that is less prevalent throughout the session stands out as more unusual when it *does* occur, in the context of the entire session).

Exploratory Findings

Correlations. This section will discuss a number of relationships among variables included and not included in the hypotheses. Although some of these relationships were

significant at the .05 level but not at the more stringent .01 level used for exploratory analyses, they are discussed here because of the exploratory nature of the present study and the concomitant importance of highlighting tentative relationships that may provide fruitful directions for this new line of research.

One finding that was significant at the .01 level was that the more supervisee negative CT behavior toward the bisexual client that supervisors perceived in the session, the less distorted was their recall of the session (i.e., the less supervisor cognitive CT); specifically, supervisors who perceived more negative CT were less likely to over-recall sexual words. A possible explanation for this finding is that the more supervisors noticed the supervisee behaving countertransferentially, the closer attention they paid to what was going on in the session, such that they had better recall of the session. In other words, the supervisee's CT behavior may have stood out to supervisors as a red flag, indicating that it was necessary to listen to the session more closely. In actual supervision settings, reasons for supervisors to listen carefully to a session once they have picked up on a supervisee's CT might be to monitor the client's welfare and to be familiar with the details of the session so they can help the supervisee process his/her CT in supervision. Although such concerns would not apply to supervisors in this analogue supervision setting, it is possible that the same processes were in operation here as might have been present in actual supervision (i.e., paying more attention, and therefore remembering a session more accurately, once aware of supervisee CT).

Much caution should be exercised in interpreting the following results, as they were not significant at the .01 level but approached significance (i.e., $.01 < p < .05$). First, it was found that supervisors who believed especially strongly in the stability of

bisexuality tended to perceive more negative CT in the session toward the bisexual client. A possible explanation, similar to the explanation given previously for related findings, is that these supervisors were especially tuned in or even hypervigilant about detecting negative CT toward the bisexual client because of their very low biphobia (i.e., positive attitudes toward bisexuals). A second finding was that supervisors who saw more negative CT toward the bisexual client tended to feel more anxious. The reason for this finding could be that supervisors felt anxious when they observed their supervisee behaving in critical or rejecting ways toward the bisexual client, especially in light of supervisors' low biphobia. Finally, supervisors who felt more anxious tended to recall fewer sexual words. A possible explanation for this finding is that supervisors' anxiety interfered with their ability to remember the session accurately (e.g., Eysenck, 1979). Alternately, this finding could mean that supervisors who felt anxious as they listened to the sexual issues discussed in the session tended to repress the session's sexual content, leading to memory distortions. In sum, it can be suggested tentatively that low-biphobia supervisors (specifically, those who believe very strongly that bisexuality is a stable sexual orientation) tended to perceive more negative CT toward a bisexual client; supervisors who perceived more negative CT toward a bisexual client tended to feel more anxious; and supervisors who felt more anxious tend to be less accurate in their memory of the sexual content of the session. Replication and further examination of these findings in future research is needed.

Over-detection of CT. Results suggested that for both positive and negative CT, supervisors tended to over-detect CT behavior rather than under-detect it. In other words, supervisors had a bias toward perceiving *more* supervisee CT behavior toward the

bisexual client than was actually there, rather than missing or failing to detect the CT behavior toward the bisexual client. This finding may be related to the extremely low biphobia in the sample. Supervisors had such positive attitudes toward bisexuals overall that they may have been particularly tuned in to perceiving supervisee behavior toward the bisexual client that was rejecting or critical. An alternative explanation relates to the study's potential demand characteristics. Participants were aware that the study was about supervision, and thus may have been looking for issues in the session that were pertinent to supervision (e.g., CT). They may have then reported more supervisee CT behavior in the session that they would have otherwise (e.g., if it was a real supervision session they were listening to). Relatedly, social desirability or political correctness may have influenced their tendency to over-detect CT; specifically, they may have reported more supervisee CT toward the bisexual client than they would have toward a heterosexual client.

Limitations

The findings of the present study must be interpreted within the context of its limitations. One limitation of the current study, similar to all laboratory analogue studies, is the generalizability of its findings to actual counseling or supervision settings (Gelso, 1979). Despite this inherent limitation, several measures were taken to increase external validity. One way of making the supervision experience as realistic as possible was having supervisor participants listen to an audiotape of the supervisee's session. Listening to a cassette tape of a supervisee's session was thought to be the most commonly used method of supervision. Additionally, to simulate the experience of supervision, participants were told to pretend that they had been meeting with the supervisee in an

ongoing, semester-long supervisory relationship. The session was also made long enough (20 minutes) to engage participants, hopefully allowing them to forget to some extent that they were listening to an analogue rather than an actual supervisee tape. Finally, both the script and the actors' performances were rated by expert judges to ensure that the analogue was realistic/believable in terms of both content and acting. Nevertheless, the scenario may have felt artificial to participants, and they may have perceived the session differently than if they had actually been listening to one of their supervisee's tapes. In spite of this possible limitation, an analogue design seemed appropriate for the present study because of the difficulty of investigating this topic in a field study.

Another possible limitation of this study was the use of only one version of the audio analogue, which did not allow for testing of actor/session effects. The second version of the analogue was not used because of low judge ratings, as well as judge comments about negative reactions to the counselor actor's speech and delivery style. We reasoned that using two versions of the analogue, with one being problematic, could have posed a more serious limitation to the study (i.e., introducing systematic error that would make results difficult to detect) than not being able to test for actor/session effects, given that previous AV analogue CT studies have not found actor effects (e.g., Hayes & Gelso, 1993; Gelso et al., 1995; Harbin, 2004). Therefore, although the use of only one version of the analogue in this study was a potential limitation, we do not believe it was a serious threat to the study's validity because the version we used received acceptable judge ratings.

Another possible limitation related to the analogue is that the positive CT behaviors in the session may arguably be appropriate, rather than countertransferential,

interventions. Specifically, what we conceptualized as the therapist's inappropriate focus on the possibility that the client is coming out as gay, and consequent invalidation of the client's bisexual identity, may actually have been an appropriate intervention given the client's presentation. A client who engages in sexual activity with members of the same sex, but keeps the activity a secret and avoids letting it develop into a relationship, may indeed be in transition to identifying as gay, and it might be appropriate on the counselor's part to explore this possibility, even if the client currently identifies as bisexual. Thus, the operationalization of positive CT in this study may be problematic; indeed, the positive CT subscale of the ICB did not relate to as many other variables as the negative CT subscale.

An additional limitation of the present study is our inability to ascertain whether supervisor CT reactions (affective and cognitive) were reactions to the bisexual client, as we conceptualized, or reactions to the session containing supervisee CT behaviors (i.e., behaviors that may have seemed inappropriate, insensitive, or unhelpful for the bisexual client). The assessment of supervisor state anxiety (affective CT) and distortion of recall of session sexual content (cognitive CT) immediately after supervisors listened to the session yields information about the extent to which supervisors experienced CT, but does not allow us to identify the trigger of the CT reaction. Future research on supervisor CT should be designed in such a way as to avoid this ambiguity, so that more definitive conclusions can be made about the relationships between supervisor CT, supervisor attitudes, and supervisor CT detection ability.

Another limitation of the study was the use of a biphobia measure (ARBS; Mohr & Rochlen, 1999) in which one of the two subscales, Tolerance, did not have adequate

reliability in the present sample (.61). While most of the relationships found between biphobia and other variables came out for the Stability subscale and not for the Tolerance subscale, any relationships between overall biphobia (which includes both subscales) and other variables should be interpreted with caution due to the low internal consistency of the Tolerance subscale.

Other limitations of the study relate to the sample of supervisors used. Although all supervisors had sufficient clinical experience to be qualified to supervise novice therapists, not all supervisors had actual supervision experience, and many supervisors were not currently supervising. Thus, it is unclear the extent to which results generalize to actual supervisors and supervision settings. Additionally, the sample had little variability with respect to biphobia; future studies might try to recruit a more diverse sample in terms of attitudes toward bisexuality. This lack of variability in supervisor biphobia posed a particular limitation for the present study in that it did not allow for testing of hypothesized differences between high and low biphobia supervisors in detection of positive versus negative CT. Finally, a larger sample size may have yielded greater power to detect relationships that approached significance in the present study. One strength of the current sample was its diversity in terms of amount of clinical experience and experience with LGB clients. Also, by including both graduate trainees and postgraduate mental health professionals, results may be generalizable to both populations.

Finally, the use of a correlational design in this study did not allow for testing of causal relationships among variables. However, results suggested a number of predictive relationships (e.g., supervisor biphobia and detection of negative CT) that may be tested experimentally in future research.

Implications for Counseling and Supervision

Although supervisors' tendency to over-detect CT in the session could have been a result of demand characteristics, one implication might be that supervisors need more training in the detection of supervisee CT toward bisexual clients (and possibly toward clients in general, although more empirical research is needed to determine whether supervisors would over-detect CT toward other types of clients). It could be helpful for supervisors to learn to watch for particular supervisee behaviors that may be indicative of CT, particularly positive CT behaviors that may seem supportive on the surface, and to be able to distinguish CT-based interventions from interventions that are based on accurate conceptualizations of the client (e.g., if the client in the present study really was in the process of coming out as gay, then some of the interventions used by the supervisee would have been appropriate). Such supervision training needs might be addressed by didactic supervision practica for graduate trainees and by continuing education and consultation for postgraduate mental health professionals. Also, if supervisors' tendency to over-detect CT toward the bisexual client was based on political correctness or hypervigilance (related to their low biphobia), an implication might be that supervisors must take into account their biases (or try to "partial out" their biases) when listening to a supervisee's session and when judging whether supervisee behaviors are indicative of CT. For example, supervisors who are relatively low in biphobia like those in the present sample might be aware that they have a tendency to over-detect supervisee CT toward bisexual clients; therefore, when addressing the supervisee's CT behavior in supervision, they could remain open to the possibility that they observed more CT than was actually there.

In contrast to LGB training literature documenting heterosexist bias among supervisors (e.g., Long, 1996; Phillips & Fischer, 1998), the current study found that supervisors' attitudes toward bisexuality were extremely positive. Supervisors believed almost unanimously that bisexuality was a moral, tolerable sexual orientation. While they disagreed about the extent to which it was a stable sexual orientation, the disagreement was between beliefs that it was *always* stable versus *sometimes* stable; no supervisors seemed to believe that it was *never* stable. This finding is consistent with more recent research suggesting that the vast majority of clinical and counseling graduate students had positive attitudes toward LGB people and issues, that the attitudes of therapists are generally more positive than the attitudes of the general public toward LGB individuals, and that the importance of LGB-affirmative therapy is becoming widely recognized (Phillips & Fischer, 1998; Bieschke, McClanahan, et al., 2000).

While it is possible that the low biphobia in this sample of clinicians is an indication that attitudes toward bisexuality are improving among clinicians in general, it is also possible that the low biphobia reflected some degree of defensiveness/political correctness/social desirability among some supervisors and possibly a need for greater understanding of the complexity of bisexuality (i.e., that it is a stable identity for some individuals while it is a transitional identity for others). One possible implication is that even "very low" biphobia supervisors may need to examine and challenge their attitudes about bisexuality (i.e., extremely positive attitudes that might be based on political correctness), especially in the interest of communicating to supervisees that it is acceptable to be conflicted or unresolved in one's attitudes about bisexuality (as opposed to communicating that supervisees must exhibit politically correct attitudes, regardless of

what they actually believe). Supervisors may also benefit from learning more about bisexuality so that they are better able to supervise trainees working with bisexual clients, as evidenced by the finding that the supervisors who understood that bisexuality was not *always* stable were better at detecting supervisee negative CT toward a bisexual client.

In the current sample, supervisors (both graduate trainees and post-graduate mental health professionals) had considerably less experience with bisexual clients compared to lesbian and gay male clients. This finding is consistent with LGB training research suggesting that graduate trainees and practicing psychologists received less training, felt less prepared, and felt they needed more training to work with bisexual clients compared to lesbian and gay male clients (Phillips & Fischer, 1998; Murphy et al., 2002). Thus, a final implication of the present study is that graduate trainees and postgraduate mental health professionals alike might benefit from more clinical experience working with bisexual clients in terms of getting more first-hand experience with the complexity of bisexual issues, so that they are able to supervise trainees who might encounter these issues in their work with bisexual clients.

Directions for Future Research

The present study was an extension of three studies: the Hayes and Gelso (1993) and Gelso et al. (1995) studies of therapist CT toward gay male and lesbian clients as a function of homophobia, and the Mohr et al. (2001) study of therapist negative *anticipated* reactions (not CT per se) to a bisexual client as a function of biphobia. It extended these three studies by investigating CT toward a *bisexual* client as a function of biphobia, although it focused on *supervisor* (rather than therapist) CT and biphobia, as well as the relationship of these variables to supervisor CT detection accuracy. A more

direct replication and extension of the Hayes and Gelso (1993), Gelso et al. (1995), and Mohr et al. (2001) studies would be an AV analogue investigating *therapist* CT toward a bisexual client as a function of *therapist* biphobia. Thus, in some respects, the present study took several steps ahead in the literature, skipping over a possible intermediate study that may have been the logical next step in this body of literature. Future research should therefore address this gap in the CT-sexual minority client literature (i.e., examining therapist biphobia as a predictor of therapist CT toward a bisexual client).

While the present study was an extension of several previous studies, it is also the first study of its type, thus yielding a variety of possibilities for further investigation. One direction for future research would be to investigate supervisor CT detection ability with other client/counselor combinations of gender and sexual orientation (e.g., heterosexual female therapist with lesbian client; lesbian therapist with bisexual female client; heterosexual male therapist with bisexual female or lesbian client). The present study used a male heterosexual counselor-male bisexual client dyad in order to increase effect size; it was thought that CT behavior, though possible in any gender/sexual orientation combination, would be the highest and the most salient in a heterosexual male counselor-male sexual minority client. Gelso et al.'s (1995) finding that female counselors had greater CT than male counselors toward an analogue lesbian client suggests that there may be interesting dynamics present in other combinations.

One particularly interesting combination might be a gay therapist-bisexual client dyad, in light of research suggesting stigma against bisexuals in the gay community (e.g., because of beliefs that bisexuals chose bisexuality as a way of maintaining some degree of heterosexual privilege, or because they were too ashamed or cowardly to embrace a

gay identity fully), especially for bisexual women in lesbian communities (Eliason, 2001; Matteson, 1996; Ochs, 1996; Morrow, 2000). Countertransference in this type of dyad might be difficult for supervisors to pick up on (thus requiring more detection ability), or at least more unexpected, than a heterosexual male supervisee having CT toward a sexual minority client. Unless they have a fair amount of experience working with these populations and knowledge of LGB community dynamics, supervisors might tend to lump together gays and bisexuals, assuming they will work well together because of their common sexual minority status. It would also be interesting to investigate other supervisor variables that could have an impact on supervisor ability to detect CT toward sexual minority clients, such as supervisor sexual orientation or level of sexual identity development.

Another variation on the present study would be to alter the nature of the supervisee's CT behavior toward the client. According to both expert raters and supervisors, the session in the present study contained more negative CT behavior toward the bisexual client than positive CT behavior. Future research could look at supervisors' CT detection ability in a session with mostly positive CT toward a bisexual or gay client, or with more specific types of CT toward sexual minority clients theorized by sexual orientation researchers, such as overcompensation due to guilt over heterosexual privilege or unconsciously rewarding bisexual clients for romantic/sexual behavior that is consistent with the sexual orientation of the therapist (Greene, 1994; Morrow, 2000).

Alternately, it would be interesting to look at whether supervisors can detect supervisee CT toward a gay or bisexual client who is not as high-functioning as the client in the present study. The bisexual client in the present study was purposely made to be

well-adjusted, satisfied with his bisexuality, and presenting with developmentally appropriate concerns, which had the potential to be pathologized in light of the client's bisexuality (e.g., career indecision and bisexuality as part of a larger problem of identity confusion). It may be easier to detect CT toward this type of client because it may be obvious that it is the counselor, not the client, who has an issue with the client's bisexuality. An interesting variation of the present study would be, then, to have a sexual minority client who is not as well-adjusted or satisfied with his or her sexual orientation, who exhibits psychopathology (e.g., depression, anxiety), or who has presenting issues that may be difficult/conflictual for a novice therapist to handle (e.g., anger over rejection by parents; Buhrke & Douce, 1991). In such a case, it may be more difficult for supervisors to tease out supervisee CT reactions from accurate conceptualizations of the client (i.e., that the client feels conflicted over his or her sexual orientation; that the client has problems functioning, etc.). Also, supervisors might have stronger CT reactions to such a client than they may have had to the healthy, well-adjusted client in the present study. Perhaps with this variation in client presentation, our prediction that supervisor CT reactions would make supervisors less accurate at detecting CT would be supported.

It would also be interesting to examine how supervisor CT detection ability might differ with supervisees working with clients representing other types of diversity, such as race, religion, disability, age, or gender identity (i.e., transgendered). Such research could investigate supervisor variables that predict CT detection ability with these different groups, such as supervisor race, universality-diversity orientation, or racial identity development if the target client was a racial minority. Also, it would be interesting to compare supervisor CT detection ability for clients from these different groups. For

example, given that racism is currently a bigger taboo in our society than homophobia, we might hypothesize that supervisors would be more accurate at detecting supervisee CT toward a racial minority client than a sexual minority client. Alternately, we might hypothesize that supervisors would be less accurate with the racial minority client, given that supervisors (or supervisees) may be more motivated to repress racist attitudes and behaviors than homophobic attitudes and behaviors. Future research could address this issue.

A particularly important extension of this line of research would be to the realm of management of supervisee CT through supervision. Although supervision is one of the primary modalities for supervisees to manage their CT, CT management in supervision may not occur unless supervisors are able to detect and initiate discussion of supervisee CT, because supervisees may not initiate discussion themselves out of lack of awareness, fear of negative evaluation, or a poor supervisory alliance (Gelso & Hayes, 2002; Williams et al., 1997; Bernard & Goodyear, 1998; Ward & Friedlander, 1985; Ladany et al., 1996; Ladany et al., 1997). No previous research has examined the process by which supervisors help supervisees manage CT (i.e., how and when they bring up the issue of supervisee CT, how they help supervisees manage CT when they also have CT toward the supervisee's client, etc.). An interesting extension to this study would be to have supervisors listen to their supervisee's 20 minute session containing CT, and then "meet with" the supervisee for a supervision session via a video analogue in which the supervisee discusses reactions to the session. Similar to the video analogue methods used in analogue CT studies (e.g. Hayes & Gelso, 1993; Gelso et al., 1995; Harbin, 2004), the video tape would contain predetermined stopping points where the supervisor would

respond to the supervisee; responses would be recorded and analyzed. Such a methodology could investigate whether or to what extent supervisors were able to detect the supervisee's CT in the session, and if detected, whether and how they address it with the supervisee in the analogue supervision session. It might also be interesting to investigate how this process is affected by supervisor variables, such as supervisor CT or supervisor attitudes toward the type of client the supervisee worked with (e.g., biphobia).

Finally, future research could test for causal relationships among variables that were correlated in the present study. For example, the more negative CT supervisors observed, the less distorted was their recall of the session (specifically, they were less likely to over-recall sexual words). Also, a number of correlations (e.g., between supervisor anxiety and amount of negative CT observed) approached significance. These tentative findings should be replicated in future studies with larger sample sizes to see if findings hold.

Appendix A: Instructions for Participants

This study is about how novice therapists react to clients who differ from them with respect to sexual orientation. Your task is to take the role of supervisor of a novice therapist working with a client of a different sexual orientation, and to evaluate this therapist's behaviors and interactions with this client.

In the supervision case you are assigned, the novice therapist, Paul, is a heterosexual male and the client, Jim, is a bisexual male. Paul meets with you on a weekly basis for supervision of his work with clients at a university counseling center. You have been supervising Paul for almost an entire semester. Paul has already mastered basic counseling skills in the beginning practica he took last year, and is currently enrolled in an advanced practicum course. Jim is an undergraduate at the university, in his junior year, and has sought counseling to discuss concerns related to family, career indecision, and relationships.

You will now listen to a tape that contains a 20-minute excerpt from Paul's second session with Jim. After listening, you will complete several measures, in which you will evaluate Paul's behavior and reactions in the session as well as report your own reactions to the session.

Appendix B: Script for Counseling Session

Counselor: Where would you like to start today?

Client: Well, I'm still thinking about whether I should apply to med school or not. If I'm gonna apply, I'm gonna need to take the MCAT this summer and I'm gonna have to start studying now. I'm just not sure if I really want to go to med school now, or at all. But then I don't know what else I'd want to do instead. I'd always thought I wanted to go to med school, and that's what my family really wants me to do. I'm afraid they'll be disappointed if I don't go.

Counselor: It sounds like it's important to you not to disappoint your family...and yet, you don't feel very certain that med school is really what you want at this point.

Client: Yeah, exactly. Like I don't want to make such a huge commitment if I'm not even sure I want to do it. I guess that's why it's been hard to even commit to taking the MCAT. If I take the MCAT and I do well, my family is going to pressure me even more to go to med school. But I don't even know if I'm up to studying for the MCAT because I've been having some trouble with my classes lately.

Counselor: What kind of trouble?

Client: Well, I haven't been able to concentrate very well this semester on classes, so my grades aren't going to be as good as usual. My GPA will still be all right but it is going to drop some. I'm a little worried about that, too, just in case I decide I do want to go to med school or some other kind of grad school. But anyway, it'd be hard to study for the MCAT's right now because I have to try to bring up my grades in my classes, plus I can barely concentrate on studying these days.

Counselor: You say you've been having trouble concentrating on academics this semester. What do you think that's about?

Client: (Sighs) I've actually had a pretty tough semester because I had to break up with my girlfriend, Sarah. It's kind of been going downhill the whole semester, you know, like things not working out with her. We had a long distance relationship—she lives back home—and that was a problem for me. So it's been kind of this long, drawn out process of breaking up, although we officially broke up, like for good, last week.

Counselor: I hear sadness in your voice as you talk about breaking up with Sarah.

Client: Yeah, I am sad about it. (pause) It was so hard to break up with her. She was crying and I just felt horrible. I told her I didn't have enough room in my life for one more commitment right now and she took it as "you don't have time for me." I guess I could see how she'd take it that way. I told her I don't want to ruin anything down the road and she said she doesn't see it working later on if it doesn't work now. It's just going to get harder. And I was like, "that may be true but I can't work it out right now."

So it's either later or never," and she was like, "ok, I still have feelings for you but if you think this is what's best then that's fine." So we were supposed to still be friends and still talk to each other. But that hasn't happened. We haven't talked at all. I guess it's just bound to end up like this but it's still awkward.

Counselor: It sounds like you were conflicted over breaking up with her.

Client: Yeah, like I felt really bad but good at the same time. I felt terrible listening to her crying over the phone. And I kept on saying "it's not you, it's not you, I just need more space right now." And she just went on and on. It was awful listening to her cry but at the same time I kept telling myself "don't give in, end it" because it's just going to get worse. So I almost felt relieved...but kind of guilty at the same time. ...but when it was over with, it was better. I was glad I did it.

Counselor: How are you feeling now as you think about it?

Client: Well, I'm glad it's over with, but I'm still wondering if I did the right thing. I know I did the right thing to end it before anything else happened. But I still feel guilty for lying straight to her face but at the same time it was the easiest way to let her down probably. You know how sometimes they say white lies are ok? I think what I told her went over better than "I cheated on you."

Counselor: What did you tell her?

Client: I told her that I couldn't handle the long distance with the way my schedule is. I'm too busy to have time to talk to her every day on the phone for an hour and I don't have time to drive there on weekends. I wasn't lying to her when I said I was too busy for the relationship, but that wasn't the only reason I broke up with her. I just didn't tell her the other reasons.

Counselor: What were the other reasons?

Client: Well, I just don't want to be tied down right now, especially by someone who's so far away. There's so much stuff to do here, so many things I want to go out and do, and my life is here and I feel like I'm being restricted by this relationship. I just want room to explore my options. And I'm not going to lie, but the physical stuff is definitely a big part of it. I mean, if she was here it would be different, but she's there so there's no physical stuff. And if I'm in a relationship with her, then I can't do physical stuff with anyone here. And I'm just not happy with that. Which is obviously why I cheated.

Counselor: So it sounds like you were feeling kind of tied down by the relationship and that it wasn't really meeting your needs.

Client: Yeah, exactly. Like I don't want to sound like a jerk or anything but I do have needs and they just weren't being met. I mean, the sex with her was great but since she's far away it just doesn't happen often enough. I'd totally be into her if she was here. I

mean she's beautiful and she's, um, she's, like, good in bed, too. And she's a great girl, too, really sweet and really cares about me. But it's just not gonna work with where I'm at right now in my life. I mean, she would be awesome for me if I was ready to settle down and we were able to be together in the same place. But, right now, even if we were in the same place, I'm still not sure that I'm ready for any commitments. I'm in college and this is supposed to be the best time of my life, when I can do and try whatever I want and be whatever I want to be.

Counselor: You're at a point in your life where you're still figuring out who you are, and you want to be able to explore your possibilities.

Client: Yeah, man, exactly. And I don't feel like I can do that if I'm tied down by this girl. I mean, that must be why I cheated.

Counselor: You keep coming back to the fact that you cheated on her. Why don't you say some more about that?

Client: Well, one of my best friends here at school is this guy, Matt. He lived on my floor during freshman year and we had some classes together, so we used to study, work out together, whatever. We've been hanging out a lot recently because he just got dumped by his girlfriend a little while ago and he was a wreck. She totally broke his heart. So anyway, we were hanging out one night at his apartment, got really wasted on some Natty Light, and one thing led to another, and basically, we, uh, hooked up. I've hooked up with guys before, but this time was kind of weird, because it was *Matt*. At first it was really awkward, we were like, "What the hell did we just do?" But he must have liked it, too, because we've been hooking up ever since!

Counselor: So do you think you feel guilty that you cheated on Sarah?

Client: I mean, a little bit, because she really wanted to be with me but I didn't feel as strongly for her. And a little bit guilty for lying to her, but I did that to protect her feelings. The thing is that I really don't feel guilty for having sex with Matt because, like I said, I'm in college, I'm free to do what I want with my life and I owe it to myself, I think, to explore my options. (Sounds hesitant, apologetic) And I don't think this is going to sound good, but I think I owe it to myself to have my needs satisfied, you know? And I have to say that I just really enjoy having sex with Matt, so I don't think I'm doing anything wrong.

Counselor: So this is a side of yourself that you really need to explore before you eventually settle down with a woman....(Long pause) Or a man.

Client: Yeah, I really think I could be satisfied with either one. I've had relationships with men before and I've had relationships with women, too. They're both good, just in different ways. As far as the sex goes, it's definitely really good with men. Maybe even better than it is with women in some ways.

Counselor: Hmm...How is it better?

Client: I don't know if I want to get into the specifics of it.... But like first of all, guys usually have more of a sex drive than women so when you put two guys together...well, you can imagine. And secondly, sometimes with girls, you kind of have to teach them how to please you because how would they know, but with another guy, he just knows what to do because he knows what he likes. And it's just very comfortable because guys think the same way, or at least they think more similarly than men and women. You don't have to have all this "communication" like you have to have when you're with a girl, you just kind of understand each other without having to talk about everything. It's pretty cool.

Counselor: So, what do you think it means that you're sleeping with a man?

Client: What do you mean?

Counselor: Well, it sounds like in some ways you feel more comfortable and more sexually satisfied with a man than with a woman. So it might mean that you're in the process of coming out as gay. That's sort of a complex process that often takes people many years—you come out to yourself and start to see yourself differently than you did before, you come out to other people like family and friends, you start to seek out the gay community...

Client: Not that I think there's anything wrong with it, but I don't really think I'm gay, man. I like women, too, just in a different way than I like men. So I consider myself bisexual. And I'm fine with it. I just think of it as having a more diverse set of tastes than other people, or maybe as being able to appreciate people regardless of their gender. Like I'm more flexible than other people somehow. There's more than one kind of person that I could be happy with. I kind of wish I knew some other bisexual people, though. I feel like I'm the only one.

Counselor: You mentioned earlier that you are in the process of exploring yourself and your options at this point in your life. It seems that one aspect of yourself that you are exploring is your sexuality, and that is a very normal process for college students. You don't need to have it figured out just yet; it is perfectly normal to be exploring.

Client: Well, it's true that I'm exploring, but I'm not sure what it is that I need to figure out that I haven't already figured out yet. I am sure that I like both men and women. What else do I need to figure out?

Counselor: Well, probably later on in your life you are going to want to settle down with a partner, a long-term relationship, even though that's not where you're at right now. So at some point, you're going to decide whether you want to be with a man or a woman, and based on that decision, whether you want to identify yourself as gay or as heterosexual. For now, it's ok not to know.

Client: But I think I'm always going to like both men and women, no matter if I'm in a relationship or not. Like I said, there's things I like about both. And maybe I'll want to settle down one day with a woman or a man, or maybe I won't. I don't know yet but I know it won't be any time soon. I want to figure out what I'm doing after I graduate and decide on a career first. That and I just kind of want to be single and enjoy myself for now.

Counselor: Jim, I'm sensing that this is a difficult topic for you to explore. You seem not to resonate with the things I'm saying to you. Is that right?

Client: I'm not sure if you understand what I'm trying to say. Maybe I haven't explained myself well enough or something.

Counselor: What don't I understand?

Client: Well, the fact that I really do like both men and women. I don't know if that's a really unusual thing, maybe it is since I don't know too many other bisexual people, and maybe you've never met anyone bisexual before, but it's not like it's something I'm exploring with the intent of eventually choosing men or women. It's just part of who I am.

Counselor: I see. So you would like me to be able to appreciate that you are attracted to both men and women. You're right, I haven't met anyone like this before you so maybe I wasn't understanding or interpreting your experience correctly. I'm sorry if you felt misunderstood. Maybe you can help me understand it better and I can learn about bisexual people from your experience.

Client: Well, thanks, man, but I don't know if I can speak for all bisexual people or anything. Like I said, I don't know too many bisexuals so I'm not sure if I'm your typical bisexual or not.

Counselor: What about your friend, Matt?

Client: I don't know about that kid. He's definitely enjoying the sex with me but he hates to admit it, thinks that it makes him gay. He's real religious so he feels guilty about it. He says he's just doing it because he's all messed up over his girlfriend dumping him and he can't be held responsible for anything crazy he might be doing right now. I don't know. If I was going to get into a relationship with a guy, it wouldn't be him even though we're close so we're comfortable with each other, because he doesn't really know what he wants and it would all have to be a big secret because his family would freak out.

Counselor: How about your family? How do they feel about you being attracted to men?

Client: My family? They know I've dated guys before and they don't have a problem with it. My parents are totally liberal. As long as I'm with a partner who makes me happy, they don't care whether it's a man or a woman. They're really a lot more

concerned about what career I decide on. It's not going to go over well if I decide not to go to med school. (Sigh)

Counselor: What about your friends? How do they feel about your sexuality?

Client: My friends? They're mostly cool with it. I haven't told any of them about Matt yet.

Counselor: Really? How come?

Client: No reason, really. Just hasn't come up yet in conversation. I'd tell them if they asked me. I don't feel any real need to tell anyone right now. It's just sex. If I was in a relationship, I'd definitely tell them. They know I broke up with Sarah.

Counselor: I'm aware that we only have 5 minutes left. How are you feeling about what we've talked about today.

Client: All right, I guess. I'm still feeling kind of stressed about deciding on med school. And I still feel a little awkward about the Sarah situation but I'm fine.

Counselor: In putting everything you've said today together, it sounds like your relationship concerns—specifically your breakup with Sarah-- are affecting your academics and your ability to make a career decision. At the same time, your career issues are affecting your ability to be in a relationship. That is, you don't want to be in a serious relationship until you have made some career decisions and gotten on the path toward a particular career. Do you think this explanation fits?

Client: Yeah, I guess it does. I guess I'm going to need to work on all of those areas in my life at once. I think it's all going to work out in the long run, things are just kind of up in the air right now. So many big decisions to make these days. First I had to decide to break up with Sarah, now I have to decide about med school...life's pretty complicated sometimes!

Counselor: This is very true! It's about time to stop for today, so let's pick up this conversation next week. I'll see you then.

Client: Ok, see you then.

Appendix C: Ratings for Script

1) Please rate the extent to which this script of a counseling session seems *believable* or realistic. Circle a point on the Likert scale below, where 1=very unbelievable (the script lacks believability/seems very unrealistic) and 5=very believable (the script seems very believable or realistic).

1	2	3	4	5
Very Unbelievable				Very Believable

2) How many sexual words/phrases were used in the script? Use your own definition of sexuality. Please go back to the script and count the words/phrases.

_____ # of sexual words/phrases in script

Instructions for Sexual Words Ratings (Consensus Meeting)

In this rating task, you will be rating the number of sexual words and phrases in the counseling session script you have in front of you.

We will go through the script speaking turn by speaking turn (therapist and client), counting the number of sexual words/phrases for each speaking turn. First, we will read the speaking turn aloud. Then, each person will circle the sexual words/phrases in that speaking turn on their paper, and write the total number of sexual words/phrases for that speaking turn in the margin. Finally, we will go through the sexual words/phrases in that speaking turn one by one (each person will say aloud the words and phrases they counted) and discuss any discrepancies, until we have reached a consensus on the words and phrases in that speaking turn that will count as sexual words/phrases.

A sexual word/phrase includes any references to sexual thoughts, feelings, behaviors, or experiences/events (excluding pronouns such as “it” or “that” etc.). Examples of such references might include “hooking up,” “had sex,” “physical stuff,” or “good in bed.” For sexual phrases that contain more than one word in the phrase (i.e. physical stuff), count the entire phrase as one entity. “Physical stuff,” for example, would count as one sexual word/phrase, not two.

Appendix D: Ratings for Tape

INSTRUCTIONS

You will be listening to two versions of the same counseling session, each approximately 20 minutes long, performed by two different pairs of actors. The session takes place at a university counseling center, where the therapist is a graduate-level practicum student, and the client is an undergraduate (junior) at the university. After listening to each version of the session, you will rate the likeability, attractiveness, and believability of the actors in that session.

Start with Session A, which is at the beginning of the enclosed cassette tape. After listening to Session A, *stop the cassette tape* (it will be clear when the session has ended). Then fill out the likeability, attractiveness, and believability ratings for both actors (therapist and client) for session A (page 2).

When you are finished filling out ratings for Session A, start the cassette tape again. Session B will begin in about 20 seconds. After listening to Session B, stop the cassette tape again. Then fill out the likeability, attractiveness, and believability ratings for both actors (therapist and client) for session B (page 3).

After listening to both sessions and completing the ratings described above, go on to page 4. The measures on page 4 ask you to make some ratings about the therapists' behaviors in the session. The therapist behaviors are essentially the same in both versions of the session that you listened to, so fill out these measures with respect to the behaviors themselves, and not in a way that is specific to the individual actors or sessions.

ACTOR RATINGS FOR SESSION A (or B)

For the following Likert scale items, circle the number on the scale that indicates your choice.

1) Please rate how *likeable* the *therapist* in Session A (B) was.

1	2	3	4	5
Very unlikeable				Very likeable

2) Please rate how *attractive* the *therapist* in Session A (B) was.

1	2	3	4	5
Very unattractive				Very attractive

3) Please rate how *believable* the *therapist* in Session A (B) was.

1	2	3	4	5
Very unbelievable				Very believable

4) Please rate how *likeable* the *client* in Session A (B) was.

1	2	3	4	5
Very unlikeable				Very likeable

5) Please rate how *attractive* the *client* in Session A (B) was.

1	2	3	4	5
Very unattractive				Very attractive

6) Please rate how *believable* the *client* in Session A (B) was.

1	2	3	4	5
Very unbelievable				Very believable

Remember to complete the following measures with respect to the therapists' behavior in general, which was essentially the same in both sessions.

Please rate the extent to which the therapist engaged in the following behaviors by writing a number in the blank next to each item, using the scale below.

1	2	3	4	5
To no extent				To a great extent

Please rate the degree of obviousness of the countertransference behaviors manifested by the therapist in the session. A rating of "1=Not obvious at all" would indicate that the countertransference behavior in the session was extremely subtle, such that only highly experienced clinicians would be able to detect it. A rating of "5=Very obvious" would indicate that the countertransference behavior was so obvious or blatant that almost any clinician, regardless of experience level, would readily be able to detect it. Circle the number that indicates your choice on the Likert scale below.

1	2	3	4	5
Not obvious at all				Very obvious

Appendix E: Instructions for Mail Participants

- 1) A general note: *In order to maintain the validity of the study, it is very important NOT to look ahead at the materials in the manila folder I have enclosed. Please only review each item as advised by the following instructions.*
Also, please set aside a 45-50 minute block of time to complete the study all in one sitting.
- 2) In the manila folder, you will first see 2 copies of the Informed Consent form. Please read this form, and sign and date both copies. Then place one copy of the form back in the manila envelope, and maintain the other copy for your records.
- 3) The next item you will find in the manila folder after the informed consent forms is a stapled packet of papers labeled “PRE-MEASURES.” Please fill out these PRE-MEASURES measures next, *without looking ahead to any of the following materials in the manila folder.*
- 4) After completing the “PRE-MEASURES,” proceed to the next item in the folder, which is labeled “INSTRUCTIONS FOR TAPE.” Please read these instructions, *again without looking ahead to any of the following materials in the folder.*
- 5) After reading the “INSTRUCTIONS FOR TAPE,” please listen to the 20-minute long session on the cassette tape. The session begins at the beginning of Side A of the tape.
- 6) Once you have finished listening to the tape, please proceed to the next stapled packet in the manila folder, labeled “POST-MEASURES.” Fill out these measures now.
- 7) After completing the “POST-MEASURES,” please fill out the Demographic form which follows.
- 8) You are now finished! You may open the envelope that is the last item in the manila folder. It contains a Debriefing form which explains what the study is about. If you have any questions about the study that are not answered by the Debriefing form, feel free to contact me at mroffman@psyc.umd.edu.
- 9) Please place all of the items (except for your copy of the Informed Consent and the Debriefing form) back in the manila folder, and mail back to be in the self-addressed, stamped envelope.

THANK YOU AGAIN FOR YOUR PARTICIPATION!

____ I'd like a written summary of the study once it has been completed.

Best address to mail or email this summary to: _____

Appendix F: Attitudes Regarding Bisexuality Scale

Instructions:

Please indicate the extent to which you agree or disagree with the following statements by writing a number in the blank next to each item, using the scale below. There are no right or wrong answers. All responses are anonymous and confidential, so please try to answer honestly.

1	2	3	4	5
Strongly Disagree				Strongly Agree

- _____ 1. Most men who claim to be bisexual are in denial about their true sexual orientation.
- _____ 2. The growing acceptance of female bisexuality indicates a decline in American values.
- _____ 3. Most women who call themselves bisexual are temporarily experimenting with their sexuality.
- _____ 4. Bisexual men are sick.
- _____ 5. Male bisexuals are afraid to commit themselves to one lifestyle.
- _____ 6. Bisexual women have a clear sense of their true sexual orientation.
- _____ 7. I would *not* be upset if my sister were bisexual.
- _____ 8. Lesbians are less confused about their sexuality than bisexual women.
- _____ 9. Bisexual men should *not* be allowed to teach children in public schools.
- _____ 10. Female bisexuality is harmful to society because it breaks down the natural divisions between the sexes.
- _____ 11. Male bisexuality is not usually a phase, but rather a stable sexual orientation.
- _____ 12. Male bisexuals have a fear of committed intimate relationships.
- _____ 13. Bisexuality in men is immoral.
- _____ 14. The only true sexual orientations for women are homosexuality and heterosexuality.
- _____ 15. As far as I'm concerned, female bisexuality is unnatural.
- _____ 16. Just like homosexuality and heterosexuality, bisexuality is a stable sexual orientation for men.
- _____ 17. Male bisexuality is *not* a perversion.
- _____ 18. Most women who identify as bisexual have not yet discovered their true sexual orientation.

Appendix G: State Anxiety Inventory

Instructions:

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate letter to the right of the statement to indicate how you felt while listening to your supervisee's taped session. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings while listening to the session best.

N=Not at all	S=Somewhat	M=Moderately	V=Very much so
1. I felt calm.....N	S	M	V
2. I felt secure.....N	S	M	V
3. I was tense.....N	S	M	V
4. I felt strained.....N	S	M	V
5. I felt at ease.....N	S	M	V
6. I felt upset.....N	S	M	V
7. I was worrying over possible misfortunes.....N	S	M	V
8. I felt satisfied.....N	S	M	V
9. I felt frightened.....N	S	M	V
10. I felt comfortable.....N	S	M	V
11. I felt self-confident.....N	S	M	V
12. I felt nervous.....N	S	M	V
13. I was jittery.....N	S	M	V
14. I felt indecisive.....N	S	M	V
15. I was relaxed.....N	S	M	V
16. I felt content.....N	S	M	V
17. I was worried.....N	S	M	V
18. I felt confused.....N	S	M	V
19. I felt steady.....N	S	M	V
20. I felt pleasantN	S	M	V

Appendix H: Cognitive Distortion Word Check

Please answer the following question by filling in the blank to the best of your knowledge:

Approximately how many sexual words/phrases were used in the session you just listened to? (Use your own definition of sexuality.) _____

Appendix I: Inventory of Countertransference Behavior

Instructions:

Please complete this form with respect to the supervisee whose session you just listened to. On the following scale, please rate the extent to which the supervisee engaged in the following behaviors by writing a number in the blank next to each item, using the scale below.

1	2	3	4	5
To no extent				To a great extent

- _____ 1. Colluded with the client in the session.
- _____ 2. Rejected the client in the session.
- _____ 3. Oversupported the client in the session.
- _____ 4. Befriended the client in the session.
- _____ 5. Was apathetic toward the client in the session.
- _____ 6. Behaved as if she or he were "somewhere else" during the session.
- _____ 7. Talked too much in the session.
- _____ 8. Frequently changed the topic during the session.
- _____ 9. Was critical of the client during the session.
- _____ 10. Spent time complaining during the session.
- _____ 11. Treated the client in a punitive manner during the session.
- _____ 12. Inappropriately apologized to the client during the session.
- _____ 13. Acted in a submissive way with the client during the session.
- _____ 14. Acted in a dependent manner during the session.
- _____ 15. Seemed to agree too often with the client during the session.
- _____ 16. Inappropriately took on an advising tone with the client during the session.
- _____ 17. Distanced him/herself from the client in the session.
- _____ 18. Engaged in too much self-disclosure during the session.
- _____ 19. Behaved as if she or he were absent during the session.
- _____ 20. Inappropriately questioned the client's motives during the session.
- _____ 21. Provided too much structure in the session.

Appendix J: Demographics Measure

INSTRUCTIONS: Please complete the following items, either by putting an X next to your choice, or by writing in responses where appropriate.

1) Gender: ☐ Female ☐ Male

2) Age: _____

3) Race/Ethnicity:

☐ African-American

☐ European American/Caucasian

☐ Asian/Pacific Islander

☐ Hispanic/Latino

☐ Native American

☐ Middle Eastern

☐ Biracial/multiracial

☐ Other (Please specify: _____)

(Please specify: _____)

4) Sexual orientation

☐ Heterosexual

☐ Bisexual

☐ Gay

☐ Other (Please specify: _____)

☐ Lesbian

5) Are you currently a graduate student/therapist/counselor-in-training?

☐ Yes (If you answered "Yes," please go on to #6)

☐ No (If you answered "No," please skip to #7)

6) If applicable, please indicate the type of graduate training program you are currently enrolled in.

☐ Counseling Psychology doctoral program

☐ Clinical Psychology doctoral program

☐ School psychology doctoral program

☐ College Student Personnel masters' program

☐ Rehabilitation Counseling masters' program

☐ Marriage & Family Therapy masters' program

☐ Other (Please specify: _____)

7) If applicable, please indicate which of the following degrees related to mental health/clinical

practice you have obtained.

☐ Counseling Psychology (Ph.D.)

☐ Social Work (LCSW)

☐ Clinical Psychology (Ph.D.)

☐ Psychiatry (MD)

☐ Clinical Psychology (Psy.D.)

☐ Marriage & Family Therapy

(Master's)

☐ School Psychology (Ph.D.)

☐ Mental Health Counseling

(Master's)

☐ College Student Personnel (Master's)

☐ Rehabilitation Counseling

(Master's)

☐ College Student Personnel (PhD.)

☐ Guidance Counseling

(Master's)

☐ Other (Please specify: _____)

8) If you are a licensed mental health professional, approximately how many years of postgraduate clinical experience do you have? ____

9) If you are a graduate student or therapist/counselor-in-training, approximately how many hours of direct clinical experience with clients would you estimate you have completed? ____

10) If you are a graduate student or counselor/therapist-in-training, how many practica have you completed? ____

(List: _____)

How many externships? ____ (List: _____)

The following questions are intended for both graduate student and mental health professional participants. These items may be more difficult for mental health professionals to answer given the large amounts of clinical experience some may have. For items that are difficult to answer, simply try to give your best estimate.

11) Approximately how many hours of direct clinical experience do you have with clients from

each of the following groups?

- ____ Gay
- ____ Lesbian
- ____ Bisexual
- ____ Transgendered

12) Approximately how many clients from each of the following groups have you worked with?

- ____ Gay
- ____ Lesbian
- ____ Bisexual
- ____ Transgendered

13) Approximately how many hours of direct clinical experience do you have as a SUPERVISOR? ____

14) Approximately how many supervisees have you worked with? ____

15) Approximately how many hours/week do you spend doing supervision? ____

16) What type of training have you had as a supervisor? (Check all that apply.)

- ____ Supervision practicum
- ____ Supervision training through externship
- ____ Supervision training through internship
- ____ Informal supervision training (i.e., working with supervisees without formal supervision training)
- ____ Other (Please describe: _____)

17) Please indicate which of the following theoretical orientations you identify with. You may rank up to 3, using 1 for the orientation you most identify with, and 2 and 3 for

additional orientations you identify with. If you only identify with one theoretical orientation, simply put an X next to this theoretical orientation.

- ☐ Psychodynamic/Interpersonal
- ☐ Humanistic/Existential/Client-Centered
- ☐ Cognitive Behavioral
- ☐ Behavioral
- ☐ Multicultural/Feminist
- ☐ Other (Please specify: _____)

THANK YOU FOR YOUR PARTICIPATION!!

Appendix K: Debriefing Form

Debrief

Thank you for participating in this study. The purpose of the study is to investigate supervisor ability to detect supervisee countertransference to a bisexual male client, as a function of supervisors' attitudes toward bisexuality and supervisors' countertransference reactions to the client. You completed several questionnaires for this study. One questionnaire measured your attitudes toward bisexuality. Another assessed your judgment of the amount and type of countertransference behavior exhibited by the supervisee in the counseling session. Finally, your own countertransference reactions to the client or session were assessed via measures of cognitive and affective countertransference that are commonly used in this area of research. .

Please be certain that your written responses to the questionnaires will be held in strict confidentiality. Under no circumstances will this be violated. Rather, your responses will only be seen as anonymous, and reports based on the findings of this study will use only aggregate data, not individual responses.

Due to the fact that many supervisors have not yet participated in this study, we must ask you not to discuss this study in detail with anyone. This is crucial to maintaining the study's validity. If you wish to speak to the study's primary investigator, please feel free to contact Missy Roffman at (240) 687-6040. Thank you again for your participation.

Appendix L: Correlation Matrix

Pearson Correlation Coefficients: Additional Analyses

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
1. Biphobia (Total) ^a	1.6	.46												
2. Biphobia (Stability) ^a	1.9	1.1	.96**											
3. Biphobia (Tolerance) ^a	1.2	.35	.76**	.55*										
4. # Sexual Words Recalled	28.0	25.8	.11	.13	.02									
5. Supervisor Cog. CT ^b	17.1	19.3	.06	.08	-.02	.73**								
6. Supervisor Aff. CT ^a	1.5	.36	-.10	-.21	.20	-.29*	-.27							
7. Supervisor Composite CT ^c	47.5	18.7	.02	.00	.06	.66**	.93**	.10						
8. Amt. CT observed (total) ^a	2.2	.51	-.07	-.09	-.01	-.27	-.35*	.15	-.31**					
9. Amt. CT observed (pos.) ^a	2.0	.53	.23	-.24	.12	.04	-.13	-.10	-.17	.77**				
10. Amt. CT observed (neg.) ^a	2.43	.67	-.27	-.30*	-.10	-.41**	-.41**	.29*	-.32	.89**	.40**			
11. CT Det. Accuracy (total) ^b	12.2	7.9	-.14	-.15	-.06	-.12	-.13	.02	-.13	.87*	.69**	.76**		
12. CT Det. Accuracy (pos.) ^b	5.7	4.7	.26	.28	.11	.04	-.10	-.13	-.15	.71	.97**	.33**	.69**	
13. CT Det. Accuracy (neg.) ^b	7.3	4.8	-.34*	-.41**	-.07	-.14	-.08	.18	-.01	.62	.20	.75	.78**	.17

Note. N = 47. ^aMean item score. ^bDeviation score. ^cSum of cognitive CT (deviation score) and affective CT (item total). *p = .05, **; p = .01.

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